IHSS

TRAINING ACADEMY

California Department of Social Services

AND

California State University, Sacramento

College of Continuing Education

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY ARNOLD SCHWARZENEGGER, Governor
DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, California 95814

TO: IN-HOME SUPPORTIVE SERVICES (IHSS) TRAINING ACADEMY PARTICIPANTS

I would like to take this opportunity to welcome you to the IHSS Training Academy. As most of you are aware, we were provided with an exceptional opportunity through legislation, Senate Bill (SB) 1104 enacted in 2004, to improve the quality of the IHSS assessment process. A key component of SB 1104 was the requirement to establish a statewide IHSS Training Academy.

The development of the IHSS Training Academy is an enormous undertaking which provides the California Department of Social Services (CDSS) and the counties with a unique opportunity to improve the quality of the IHSS assessment process throughout California. Improving the quality of the assessment process will have a positive impact on the program consumers.

Since IHSS began in 1973, we have never before had an opportunity to ensure that all staff performing assessments receives the same level of training. In addition to staff directly involved in the assessment process, training will be made available to Administrative Law Judges, Public Authority staff, and staff at the county level who do not perform assessments, but are connected in some way through their jobs with the assessment process.

The CDSS has partnered with California State University, Sacramento (CSUS) College of Continuing Education (CCE) and Institute for Social Research (ISR) who is responsible developing and delivering the training. Curriculum for the IHSS Training Academy was developed in conjunction with input from counties through surveys, the California Welfare Directors' Association (CWDA), and the IHSS Training Workgroup established in accordance with SB 1104 requirements. CSUS has hired county staff that is familiar with the IHSS assessment process to act as trainers and subject matter experts for this training.

We hope that you enjoy the time spent in training and are looking forward to receiving your feedback regarding the training as well as recommendations for future training topics.

Sincerely,

Joseph M. Carlin

JOSEPH M. CARLIN
Acting Deputy Director
Disability and Adult Programs Division

CALIFORNIA STATE UNIVERSITY, SACRAMENTO
COLLEGE OF CONTINUING EDUCATION

California State University, Sacramento (CSUS) is a state department of higher education, which is under the management, administration and control of the California State University System, Board of Trustees. The CSUS is one of twenty-three campuses, which directly report to the Chancellors Office.

The mission of the College of Continuing Education (CCE), as an extension of CSUS, is to encourage lifelong learning by providing opportunities for personal and professional growth. To achieve this goal, CCE has been offering courses, seminars, institutes, workshops and conferences in local, regional and statewide settings since 1951. Through daily observations with leaders in both public and private sector organizations, the CCE program development staff is able to identify diverse educational needs of the statewide workforce and design programs that meet those needs.

Courses are developed and taught by noted instructors who are especially well qualified in their subject matter. The instructors may be University faculty or highly regarded practitioners who are on the leading edge of their professional fields.

Further information about CCE can be found at http://www.csus.edu/rce/stc/.

INSTITUTE FOR SOCIAL RESEARCH

Ernest L. Cowles, Ph.D., Director

The Institute for Social Research is an interdisciplinary center established in 1989 to serve the research needs of federal, state and local government agencies, non-profit organizations, and the University, its faculty and students. University faculty in the social sciences, health and human services, education and engineering and supplement its full time staff as projects require their specialized expertise. Since its inception the ISR has conducted a sizeable number of research studies and worked with over 50 agencies on various projects. ISR's projects have concentrated on social services, criminal justice, environmental and health policy issues. Throughout its history the ISR has developed a reputation for the quality of its products.

ISR's role in the IHSS Training Academy project involves several elements. One portion is to conduct an assessment of the training and its subsequent impact on the work of the participants. A second focus is to help the CDSS and its Time for Task workgroups by collecting and analyzing information from focus groups with IHSS providers, consumers, and social workers. A third component is to collect information on time per task guidelines existing in other states to provide a comparative perspective for the effort being undertaken in California. Finally, the ISR provides general technical assistance to the project drawing from its research experience since the early 1990s regarding personal care services provided in the home.

(e) The department shall, in consultation with counties and in accordance with Section 12305.72, develop a standardize curriculum, training materials, and work aids, and operate an ongoing statewide training program on the supportive services uniformity system for county workers, managers, quality assurance staff, state hearing officers, and public authority or nonprofit consortium staff, to the extent a county operates a public authority or nonprofit consortium. The training shall be expanded to include variable assessment intervals, statewide hourly task guidelines, and use of the protective supervision medical certification form as the development of each of these components is completed. Training shall be scheduled and provided at sites throughout the states. The department may obtain a qualified vendor to assist in the development of the training and to conduct the training program. The design of the training program shall provide reasonable flexibility to allow counties to use their preferred training modalities to educate their supportive services staff in this subject matter.

IHSS Training Academy

Purpose

The purpose of Phase 1 of the IHSS Training Academy is to promote consistent assessment and assignment of functional levels and of authorization for needed IHSS services.

Objectives

At the end of the program the participants will be able to:

- Identify the overall purpose of the IHSS quality initiative.
- Understand the impacts of differing service authorization practices on both the consumers and on the system.
- Explain the importance of differentiation between consumer needs and preferences when authoring service.
- Identify successful interviewing techniques of consumers, family members and providers in complex situations,
- State methods that can be used to maximize assessment accuracy for consumers and families with complex issues.
- Understand the importance of documentation in creating a clear picture of consumer's needs and in substantiation of the authorization process.
- Identify successful techniques in communicating with consumers and families in difficult situations.
- Demonstrate an ability to identify the impact of living arrangements upon the authorization of service hours.
- Recognize the need for reauthorization of consumer needs and identify consumers that would be reauthorization priorities.
- Demonstrate the ability to identify practice challenges through the review of case records.

Day 1 Map/Notes

IHSS Training Academy

Day 1: Assessing Needs

- Welcome / Housekeeping
    - Pre-assessment
    - Introductions
    - Parking Lot
    - Overview of Day /Expectations
- Why IHSS Training? / Purpose of the Training Academy
- Uniformity Review/Overview
- Gathering Information from Clients
    - Assessment Process
    - Assessment Sources
- Assessment Challenges
    - Providers /family that want to speak for the consumer.
    - Consumers who understate their need.
    - Consumers who overstate their need.
    - Angry Consumers
    - Hostile Consumers
    - Emotionally distraught Consumers
    - People dealing with grief /loss issues.
    - Consumers dealing with impact of chronic illness.
    - Hard of hearing
    - Blind
    - Cultural issues
    - Dementia / Alzheimer's
    - Consumers with mental illness
- Assessing Needs –Joe and Emily
- END OF DAY 1: Comments / Evaluations

IHSS Training Academy

Day 1: Assessing Complex Needs

Pre Assessment Evaluation

In Home Supportive Services Training Academy Partnership

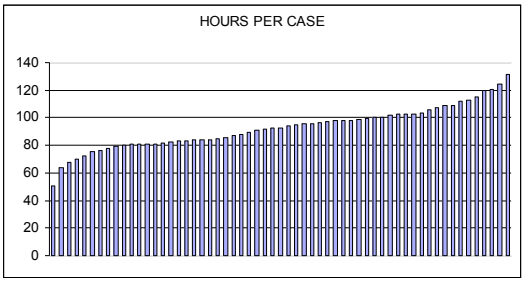
- California Department of Social Services
- California State University, Sacramento
  - College of Continuing Education
  - Institute for Social Research

The College of Continuing Education has been working with a team of instructional designers, subject matter experts, and trainers to develop curriculum in conjunction with input from counties through surveys, the California Welfare Directors' Association (CWDA), and the IHSS Workgroup established in accordance with SB 1104.

Why IHSS Training?

- Need for consistency in authorization practices
- Increasing complexities of IHSS with 3 programs – PCSP, Waiver and IHSS Residual
- Need for standardized training for staff performing assessments
- Legislative mandate SB1104

Variance in Statewide Authorization of hours



The monthly average statewide is approx. 85 hrs. State data, 7/05.

SB 1104 – Quality Assurance

- Statewide social worker training to improve and standardize assessment process.
- Develop hourly task guidelines by 6/06.
- Workgroup currently addressing regulations through revision process and creating emergency regulations.
- Enhance State and local fraud and data evaluation activities.
- Establishment of dedicated QA function at county level with State monitoring.

Prerequisites for Uniformity

- Consumer's needs are evaluated the same way.
- Workers all over the state apply the same standards when assessing function.
- The rankings of the scales are applied the same.

Outcomes

- When consumers with similar needs receive similar services, ***all consumers have an equal opportunity to experience independence and safety.***
- Assessment standards ***promote consistency and fairness*** –across the state and within counties.

Functional Index Scale [MPP 30-756]

- ***Independent***
- ***Verbal Assistance***
- ***Some Human Help Needed***
- ***Lots of Human Help***
- ***Cannot Perform***
- ***Paramedical Services***

Functional Scales Include

- Housework
- Laundry
- Shopping and Errands
- Meal Preparation and Clean-up
- Mobility Inside
- Bathing and Grooming
- Dressing
- Bowel, Bladder and Menstrual
- Transfer
- Eating
- Respiration
- Memory
- Orientation
- Judgment

Gathering Information from Consumers





Performance Based Assessment

Observe consumer for assessment data related to:

- Safety
- Independence
- Abilities
- Performance in key functional areas

Interview Success in a Complex Assessment

- Avoiding Bias –
  - Don't express your own opinions – consumers will change their answers to make you happy.
  - Don't suggest answers if consumer wants your help – repeat the question, pause and let them take a moment.
  - Avoid leading probes that might suggest an answer.

From "Doing the Interview: how to really ask those questions and enjoy it"

Interview Success in a Complex Assessment

- Use Probes for Clarity and Completeness
  - "*You said….What do you mean by that?"*
  - *"I'm not sure I understand. Could you give me more information?"*
  - *"Could you explain that, tell me more about that?"*

From "Doing the Interview: how to really ask those questions and enjoy it"

Interview Success in a Complex Assessment

- Tread Carefully – but don't avoid embarrassing subjects
  - Build rapport at beginning of interview.
  - Reassure consumer you are not embarrassed.
  - Ask questions straightforwardly and without hesitation.
  - Explain these are questions you ask everyone.

From "Doing the Interview: how to really ask those questions and enjoy it"

Other Assessment Cues

Non-Verbal

- Eye Contact
- Facial expressions
- Tone / Inflection of voice
- Discrepancies between what consumers say and what they do

Environmental Observations

- Discrepancies between the way the environment looks and what consumer reports as service needs

Sensory Cues

- Smell
- Tactile information –sticky floors, surfaces

Your Body Speaks your Mind

Between 60-80% of our message is communicated through our Body Language, only 7-10% is attributable to the actual words of a conversation.

Whenever there is a conflict between verbal and non-verbal, we almost always believe the non-verbal messages without necessarily knowing why.

Other Resources for Assessment Information

- Family Members
- Providers
- Informal Support System
- MSSP, Linkages
- Day Programs
- Medical Verification
- Regional Centers
- Senior Centers
- Senior Apartment –
  - Staff
- Other sources

Key Points to Remember

- Habits may differ from actual ***abilities.***
- Focus on ***functioning***, rather than on a medical diagnosis.
- Assistive devices often promote ***independence*** – don't necessarily indicate additional impairment.
- Authorization of services is based on client ***safety and independence.***
- Assessment should focus on ***needs versus wants*** of the consumer.

Assistive Devices

Durable Medical Equipment (DME)

- Importance of DME:
  - Promotes consumer independence
  - Improves quality of life and satisfaction
  - Can greatly effect consumer functional ability
- Assess the consumer's use of and possible need for DME.
- Must have medical prescription for payment of DME.
- Document DME and how it effects the consumer's independence when assigning functional scores and authorizing services.

H LINE Exercise: Client with Assistive Devices

- Using provided scenario, determine the H line for the areas identified:
  - Domestic
  - Meal Preparation and Cleanup
  - Bathing and Grooming
  - Dressing
- Record your answers and report out

Assessment Challenges

- Providers / family that want to speak for the consumer
- Consumers who understate their need
- Consumers who overstate their need

H LINE Exercise: Clients who Over and Understate Needs

- Using provided scenario, determine the H line for the areas identified:

  Kimberly
  - Domestic
  - Meal Preparation
  - Transfer
  - Bowel and bladder

  Alice
  - Domestic
  - Meal Preparation
  - Ambulation
  - Bathing and Grooming

- Record your answers and report out

Assessment Challenges

- Angry consumers
- Hostile consumers
- Emotionally distraught consumers

Assessment Challenges

- People dealing with grief / loss issues
- Consumers dealing with impact of chronic illness

GRIEF
Dealing with Chronic Disease
LOSS
Stress

Assessment Challenges

- Hearing impairments
- Visual impairments
- Cultural issues

Assessment Challenges

- Dementia / Alzheimer's
- Consumers with mental illness

Alzheimer's

First Noticeable symptoms:

- Loss of memory
- Trouble performing tasks
- Poor judgment
- Misplacing things
- Inability to think and understand
- Gradual changes in behavior

Tips / Recommendations:

- Safety precautions such as ID bracelet, or other form of identification
- Recommend a baby monitor or door alarm
- Utilize community support groups and Adult Day Care

Schizophrenia

Characteristics

- Affects around 1 percent of the American population.
- "positive" and "negative" symptoms:
  - ***Positive symptoms:*** active symptoms, including delusions, hallucinations, disorganized thinking, and disorganized behavior.
  - ***Negative symptoms:*** loss in functioning, including withdrawal or lack of motivation, inability to feel pleasure, lack of verbal speech, or flat affect.

Schizophrenia

IHSS Functional Limitations

- **Concentration or sleep can deteriorate**, *cooking, cleaning, or shopping.*
- **Delusions or hallucinations can consume all their energy**, *cleaning, shopping, or paying bills, eviction, unable to use appliances.*
- **The "negative" symptoms can cause a total lack of motivation,** *cleaning self, domestic, or dress changes.*
- **Remember:** It's beyond their capacity to become motivated.

Schizophrenia

- Many self-medicate with alcohol and/or substance abuse.
  - Attempting to quell the tortuous pain.
  - Avoid Bias - Be aware of your own issues with the alcoholism or substance abuse.

Schizophrenia

Techniques for Interactions

- **Use short simple phrases.**
- **Use a calm and unhurried tone of voice.**
- **Never shout or try to argue with the client.**
- **Give the client physical space and try to avoid too much direct eye contact.**
- **If the client is tangential, politely redirect by recapping, and then move on to your questioning.**

Schizophrenia

Techniques for Interactions

- **Never be judgmental or put blame on the client.**
- **Do not try and convince the client their delusions or hallucinations are fake.**
- **Do not go along with hallucinations, pretending you are experiencing them as well.**
- **Eliminate unnecessary noises in the apartment.**
- **If the client can not calm down and appears very angry, excuse yourself politely and leave.**

Depression

Characteristics

- sad or tearful.
- posture, gait, and speech are slow.
- decreased tone when speaking.
- Alcohol/drug use may be present.
- complain of restlessness or sleep deprivation.
- show excessive weight loss or weight gain.
- express feelings of excessive guilt or worthlessness.
- may also exhibit anxiousness or anger.
- lost interest in activities that were once pleasurable.
- memory problems or difficulty concentrating.
- loss of energy or have fatigue.
- lives alone and/or was close to someone who recently passed away.
- talk about death or express suicidal thoughts.

Depression

IHSS Functional Limitations

- **Lack of concentration**,
  bill paying, or shopping can be difficult.
- **Sense of worthlessness or apathy,**
  self care, bathing, cleaning.
- **Depression,**
  lack of appetite and a desire to cook.
- **Severe depression,**
  difficult for a client to even get out of bed.

Depression

Techniques for Interactions

- **Develop rapport.**
- **Establish trust**.
- **Show empathy.**
- **Listen to the client.**
- **Do not blame the client.**
- **Separate the disorder from your client.**
- **Do not offer empty promises like "things will be okay".**
.
- **Find a private place to talk**.
- **Observe for signs of suicide risk.**

Hoarding

Characteristics

- Can occur at any age.
- May be related to more than just obsessive-compulsive traits as a person ages.
- May have fear of losing items.
- May be using items as a psychological replacement for loved ones and friends.
- Elders may also hoard due to generational concerns, such as surviving the Great Depression.
- Throwing away a client's clutter can be psychologically damaging to the client.
- Hoarding behaviors may serve as a coping mechanism against depression, like drugs or alcohol.

Hoarding

IHSS Functional Limitations

- **Blockage to walkways and doorways**, *can limit a person's ability to ambulate- increase fall risk.*
- **May store items in the bathroom,** *affecting ability to bathe or use the toilet.*
- **May obstruct ovens, stoves, and refrigerators,** *making it difficult to cook, store food.*

Hoarding

Techniques for Interactions

- **Refrain from calling a client's clutter "junk" or "trash".**
- **Approach with respect and non-judgment, showing that you do not mind the condition of the apartment.**
- **Use a gentle approach.**
- **The client should be involved in the process of any clean-up.**

Hoarding

Techniques for Interactions

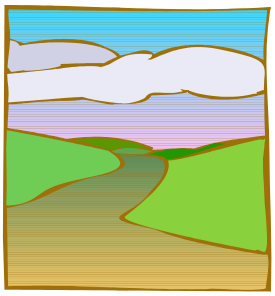
- **An appeal to the client's safety and/or risk of eviction may be helpful motivating factors.**
- **Be assertive, yet caring, focusing on a risk for falls, safety hazards, threat of eviction, or threat of public health involvement.**
- **Consult with supervisor and/or make a referral to Adult Protective Services or appropriate mandated reporting agency if clutter becomes a great risk to the client.**

Assessing Needs

Joe & *Emily*

Exercise: Assessing Needs

- Read scenario – share roles
- Complete Assessment Worksheet and SOC 293 H LINE *ONLY*
- Create a narrative of your assessment
- Put H Line FI scores on flip chart for report out
- Be prepared to discuss the assessment data you have to support FI scores identified



End of Day 1

Thanks for your participation!

PLEASE fill out the evaluation form

Annotated Assessment Criteria

Annotated
Assessment Criteria

This Annotated Assessment Criteria handout is for reference in assisting you in determining difficult rankings. It describes each rank in more detail and describes observations you might make for each ranking, examples of the kind of consumer who might be ranked at each level and sample questions which might elicit the information needed to determine the appropriate rank. These are lists of possible indicators, not definitive standards.

GENERAL

Following are general questions to be asked of applicants to determine whether need exists:

- How frequently have you been seen by a doctor?
- Has the doctor limited your activities?
- When does your family come to see you and how do they feel about your condition?
- What can family/friends/neighbors do to help you?
- Who has been helping you up to this point?
- Why are you asking for help now?
- How have circumstances changed?
- How long have you been having difficulty?
- What is limiting your activities?
- How do you feel about the status of your health?
- How long do you think you will need this service?
- How would you manage if your provider called in sick one day?

Information to be given and reinforced periodically

- A clear explanation of the recipient's responsibilities in the county's delivery system.
- IHSS is a program which provides only those services necessary for consumer safety which the consumer is unable to perform, and is not a maid or baby-sitting service.
- Social workers should encourage the consumer to perform any tasks at all that they can. This is not a ploy to save the program money, but contrarily to discourage the person from being totally dependent on others. Sometimes the manual dexterity and coordination can be prolonged if the consumer will exercise his/her hands and arms.

OBSERVATIONS

A number of observations are applicable to all functions. These are: getting up from a chair; ambulation; standing; reaching; grasping; bending; carrying; endurance; mentation. In the following text, the first eight observable behaviors above are referred to as "movement." All of these functions can usually be observed by noting how the consumer admitted you into the housing unit, shaking his/her hand when arriving, asking the consumer to show you all medications, to show you the housing unit, to get his/her Medi-Cal card for you and to sign the application. If the above-listed functions have not been adequately demonstrated in the course of the interview, it is sometimes helpful to ask the consumer for a glass of water. Since the ranking of functioning is hierarchical, observations and questions in a lower rank are likely to apply to a higher one. Observations lead to a general guess as to the appropriate level of functioning, and follow-up questions elicit information as to what assistance is necessary for the level of client functioning observed. This listing is not inclusive, nor does the presence of one behavior on the list necessarily create the basis for the ranking. All your senses are involved in gaining cues as to the consumer's functioning as a whole. Quite often, it is important to get a medical report to verify that there is a basis for observed

behaviors.

GENERAL

The following are general standards which apply to all functions. The standards for each function are defined in more detail in individual scales which follow.

Rank 1: Independent: able to perform function without human assistance though consumer may have difficulty; completion of the task with or without a device poses no risk to his/her safety.
Rank 2: Able to perform but needs verbal assistance such as reminding, guidance or encouragement.
Rank 3: Can perform with some human help; i.e., direct physical assistance from the provider.
Rank 4: Can perform with a lot of human help.
Rank 5: Cannot perform function at all without human help.
Rank 6: Paramedical Services needed.

HOUSEWORK

Sweeping, vacuuming, and washing floors; washing kitchen counters and sinks; cleaning the bathroom; storing food and supplies; taking out garbage; dusting and picking up; cleaning oven and stove; cleaning and defrosting refrigerator; bringing in fuel for heating or cooking purposes from a fuel bin in the yard; changing bed linen.

Rank 1: Independent: able to perform all domestic chores without a risk to health or safety

- **Observations –** Neat and tidy apartment; consumer's movement unimpaired
- **Example –** Consumer with no signs of impairment moves easily about a neat room, bending to pick up items and reaching to take items from shelves
- **Questions –** Are you able to do all the household chores yourself, including taking out the garbage? (Consumer able to do all chores, although (s)he might have to do a few things every day so that (s)he doesn't overexert herself/himself.)

Rank 2: Able to perform tasks but needs direction or encouragement from another person

- **Observations** – Consumer seems confused or forgetful but no observable physical impairment severe enough to seem to limit ability to do housework; incongruity in what you observe such as dirty dishes in cupboard
- **Example** – Young man, apparently physically healthy but obviously confused and forgetful, is being reminded that it is time for him to prepare his dinner
- **Questions** – How do you manage to keep your apartment clean? Has anyone been helping you up to this time? (Consumer able to perform chores if daughter makes her a list or someone reminds.)

Rank 3: Requires physical assistance from another person for some chores; e.g., has a limited endurance or limitations in bending, stooping, reaching, etc.

- **Observations:** Consumer has some movement problems as described above, limited endurance, easily fatigued or severely limited eyesight; apartment is generally tidy but needs a good cleaning; it is apparent that consumer has made attempts to clean but was unable to.
- **Example:** Small, frail woman answers apartment door; apartment has some debris scattered on carpet, trash can sitting in kitchen area quite full; remainder of apartment neat
- **Questions:** Have you been doing the housework yourself? What have you been doing about getting your housework done up until now?

Rank 4: Although able to perform a few chores (e.g., dust furniture or wipe counters) help from another person is needed for most chores

- **Observations:** Consumer has limited strength and impaired range of motion; house needs heavy cleaning
- **Example:** Consumer walking with a cane, breathing heavily, in cluttered living room; bathtub and toilet in need of cleansing; client's activities limited because of shortness of breath and dizziness
- **Questions:** What household tasks are you able to perform? Has your doctor limited your activities?

Rank 5: Totally dependent upon others for all domestic chores

- **Observations:** Dust and debris apparent, bathroom needs scouring, obviously unattended for some time; garbage can odors apparent; consumer obviously has very limited mobility or mental capacity
- **Example:** Bed bound consumer, able to respond to questions, no movement in arms or legs. Frail elderly man, recovering from heart surgery, forbidden by doctor to perform any household chores
- **Questions:** Are there any household tasks you are able to perform? What is limiting your activities? Who has been helping you to this point?

LAUNDRY

Gaining access to machines, sorting, manipulating soap containers, reaching into machines, handling wet laundry, operating machine controls, hanging laundry to dry, folding and sorting. Ability to iron non-wash-and-wear garments is ranked as part of this function only if this is required because of the individual's condition; e.g., to prevent pressure sores or for employed recipients who do not own a wash-and-wear wardrobe.

Rank 1: Independent: Able to perform all chores

- **Observations:** Movement seems unimpaired; consumer seems able to ambulate, grasp, bend, lift, stand adequately; is wearing clean clothes
- **Example:** Consumer apparently physically fit. Consumer's movements during interview indicate that (s)he has no difficulty with reaching, bending, lifting
- **Questions:** Are you able to wash and dry your own clothes? Are you also able to fold and put them away?

Rank 4: Requires assistance with most tasks. May be able to do some laundry tasks; e.g., hand wash underwear, fold and/or store clothing by self or under supervision

- **Observations:** Some impairment in movement noting or forgetfulness or severely limited eyesight; clothing stained or spotted
- **Example:** Frail woman unable to transfer wet wash to the dryer, particularly sheets and towels; housemate encourages consumer to help with sorting and folding, etc.
- **Questions:** Are you able to lift and transfer wet articles in the laundry? How have you handled this laundry up to now? Who has been doing your laundry for you up to this time? Has the doctor suggested that you do some simple tasks with your arms and hands?

Rank 5: Cannot perform any task. Is totally dependent on assistance from another person

- **Observations:** Severe restrictions of movement
- **Example:** Quadriplegic consumer seated in wheelchair, obviously unable to perform laundry activities
- **Questions:** Who does your laundry now? What has changed in your circumstances which resulted in your asking for help now?

SHOPPING AND ERRANDS

Compile list, bending, reaching, and lifting, managing cart or basket, identifying items needed, transferring items to home, putting items away, phoning in and picking up prescriptions, and buying clothing.

Rank 1: Independent: Can perform all tasks without assistance

- **Observations:** Movement seems unimpaired and consumer seems oriented
- **Example:** Social worker questions elderly man whose responses indicate that he is able to do his own shopping and can put groceries and other items away**.** Although his movements are a little slow it is evident that he is capable of performing this task.
- **Questions:** How do you take care of your shopping and errands?

Rank 3: Requires the assistance of another person for some tasks; e.g., help with major shopping needed, but consumer can go to nearby store for small items or needs direction or guidance

- **Observations:** Movement somewhat impaired; consumer has poor endurance or is unable to lift heavy items; or consumer seems easily confused; or severely limited eyesight; limited food stuffs on hand in refrigerator and cupboard
- **Example:** Consumer goes to corner market daily to get a few small items or someone else makes a shopping list
- **Questions:** Do you have difficultly shopping? What are the heaviest items you are able to lift? Do you usually buy the items you planned to purchase? Do you have any difficulty remembering what you wanted to purchase or making decisions on what to buy? Ask significant other whether consumer has difficulty making decision on what to buy if consumer's mental functioning seems impaired.

Rank 5: Unable to perform any tasks for self

- **Observations:** Movement or mental functioning severely limited
- **Example:** Neighbors help when they can, teenaged boy comes to consumer's door, receives money and list from consumer to purchase a few groceries
- **Questions:** Has someone been shopping for you? How do you get your medications?

MEAL PREPARATION AND CLEANUP

Planning menus. Washing, peeling, slicing vegetables, opening packages, cans and bags, mixing ingredients, lifting pots and pans, reheating food, cooking, safely operating stove, setting the table, serving the meal, cutting food into bite-sized pieces. Washing and drying dishes, and putting them away.

Rank 1: Independent: Can plan, prepare, serve and cleanup meals

- **Observations:** Movement seems unimpaired
- **Example:** Consumer cooks and freezes leftovers for reheating
- **Questions:** Are you able to cook your own meals and cleanup afterwards? Are you on a special diet? If yes, describe.

Rank 2: Needs only reminding or guidance in menu planning, meal preparation and/or cleanup

- **Observations:** Consumer seems forgetful; rotten food or no food in refrigerator, or a stockpile of Twinkies, only; clothes too large indicating probable weight loss; no signs of cooking
- **Example:** Elderly client unable to plan balanced meals, has trouble knowing what to eat, so she eats a lot of desserts and snacks, sends granddaughter to purchase fast foods
- **Questions:** Are you able to prepare and cleanup your own meals?

Rank 3: Requires another person to prepare and cleanup main meal(s) on less than a daily basis; e.g., can reheat food prepared by someone else, can prepare simple meals and/or needs help with cleanup on a less than daily basis

- **Observations:** Movement impaired; poor strength and endurance; or severely limited eyesight; appears adequately nourished and hydrated
- **Example:** Consumer can reheat meals, snacks from the package and make sandwich
- **Questions:** What type of meals are you able to prepare for yourself? Can you lift casserole dishes and pans? Can you reheat meals that were prepared for you ahead of time?

Rank 4: Requires another person to prepare and cleanup main meal(s) on a daily basis

- **Observations:** Movement and endurance problems; very limited strength of grip
- **Example:** Consumer unable to stand for long periods of time; can get snacks from the refrigerator like fruit and cold drinks, cereal or make toast for breakfast, etc.
- **Questions:** Can you stand long enough to operate your stove?

Rank 5: Totally dependent on another person to prepare and cleanup all meals

- **Observations:** Severe movement problems or totally disoriented and unsafe around the stove
- **Example:** Provider cuts up food in bite-sized portions and carries tray to bed bound consumer
- **Questions:** Are you able to prepare anything to eat for yourself? Does your food and drink need to be handled in any special way?

Rank 6: Is tube-fed. All aspects of tube feeding are evaluated as a Paramedical Service.

MOBILITY INSIDE

Walking or moving around inside the house, changing locations in a room, moving from room to room. Can respond adequately if (s)he stumbles or trips. Can step over or maneuver around pets or obstacles, including uneven floor surfaces. Climbing or descending stairs if stairs are inside dwelling. Does **not** refer to transfers, to abilities or needs once destination is reached, to ability to come into or go out of the house, or to moving around outside.

Rank 1: Independent: Requires no physical assistance though consumer may experience some difficulty or discomfort. Completion of the task poses no risk to his/her safety

- **Observations:** Consumer steady on feet; able to maneuver around furniture, etc.; does consumer need to grab furniture or walls for support? Have consumer show you home and observe ambulation.
- **Questions:** Do you ever have any difficulty moving around? Have you ever had to use a cane or walker? Do you feel safe walking alone in your home?

Rank 2: Can move independently with only reminding or encouragement. For example, needs reminding to lock a brace, unlock a wheelchair or to use a cane or walker

- **Observations:** Does consumer use her walker or cane of her own volition? Does consumer rely appropriately on appliance? Is there an assistive device visible in a corner rather than right beside the consumer when (s)he is sitting? How well is consumer able to move about with assistive device? Are there any modifications observable in the home such as grab bars, etc?
- **Questions:** Do you ever have trouble handling your device? Are there times when you forget and get somewhere and need help getting back or do not wish to use your device? What happens then? Have you experienced any falls lately? Describe.

Rank 3: Requires physical assistance from another person for specific maneuvers; e.g., pushing wheelchair around sharp corner, negotiating stairs or moving on certain surfaces

- **Observations:** Does consumer need to ask you for assistance? Does consumer appear to be struggling with a maneuver that could put her at risk if unattended? Does consumer appear strong enough to handle the device? Are there architectural barriers?
- **Questions:** Are there times when you need to rely on someone else to help you get around the house? What kind of help do you need and when? What happens when there is no one to help you? Are there certain times of day or night when movement is more difficult for you? Are all areas of your home accessible to you?

Rank 4: Requires assistance from another person most of the time. At risk if unassisted

- **Observations:** Was consumer able to answer the door? Get back safely to seat? Is there clutter on the floor or scatter rugs or stairs? Is there obvious fatigue or labored breathing? Are there bruises, scabs, or bumps on head or burns (signs of falls)?
- **Questions:** Is there someone in the home helping you now? If so, what is the level of assistance?

Rank 5: Totally dependent upon others for movement. Must be carried, lifted or pushed in a wheelchair or gurney at all times

- **Observations:** Does consumer appear to be immobile? Does (s)he appear to be uncomfortable

or in pain? Does (s)he experience skin breakdown? Does (s)he have any fears related to being moved? Can consumer make needs known?

* **Questions:** Who is available to help you when you need to be moved? Do you feel they are able to do so without causing you undue pain or discomfort? Is there anything that needs to be changed to make you more comfortable?

BATHING AND GROOMING

Bathing means cleaning the body using a tub, shower or sponge bath, including getting a basin of water, managing faucets, getting in and out of a tub, reaching head and body parts for soaping, rinsing, and drying. Grooming includes hair combing and brushing, shampooing, oral hygiene, shaving and fingernail and toenail care (unless toenail care is medically contraindicated and therefore is evaluated as a Paramedical Service). NOTE: Getting to and from the bathroom is evaluated as Mobility Inside.

Rank 1: Independent: Able to bathe and groom self safely without help from another person

* **Observations:** Mobility unimpaired; consumer clean and well groomed; observe if there is equipment in the bathroom
* **Questions:** Do you ever require any assistance with bathing or grooming? Are you able to get in and out of the tub or shower safely? Have you ever fallen?

Rank 2: Able to bathe and groom self with direction or intermittent monitoring. May need reminding to maintain personal hygiene

* **Observations:** Body odors, unwashed hair, dirty, un-manicured fingernails, unshaven, lack of dental hygiene and general poor grooming habits; unaware of appearance
* **Questions:** Are there times when you forget to bathe and groom yourself, or it seems just too much bother? Does anyone help you organize your bath or shower?

Rank 3: Generally able to bathe and groom self, but needs assistance with some areas of body care: e.g., getting in and out of shower or tub, shampooing hair, or can sponge bathe but another person must bring water, soap, towel, etc.

* **Observations:** Weakness or pain in limbs or joints; difficulty raising arms over head; frailty, weakness, unsteady gait indicating a safety risk; bathroom not set up to meet consumer's safety needs (i.e., grab bars, tub bench) but consumer could sponge bathe if water is brought to the consumer; consumer grooming indicates an unaddressed need
* **Example:** Consumer has fear with associated lack of movement
* **Questions:** Are there areas of bathing or grooming that you feel you need help with? What? When? How do you get into the shower or tub? Do you ever feel unsafe in the bathroom? Have you ever had an accident when bathing? What would you do if you did fall?

Rank 4: Requires direct assistance with most aspects of bathing and grooming. Would be at risk if left alone

* **Observations:** Requires assistance with transfer; poor range of motion, weakness, poor balance, fatigue (i.e., indications of a safety risk; how accessible and modified is bathroom for consumer's needs?); skin problems
* **Questions:** How much help do you need in getting a bath and washing your hair? If there was no one to help you, what would be left undone? Do you experience any loss of sensation to your body? Do you have any fears related to bathing? Have you fallen when getting into or out of the tub or shower?

Rank 5: Totally dependent on others for bathing and grooming

* **Observations:** Is there any voluntary movement? Where? Does consumer exhibit good skin

color, healthy, clean skin and hair? Are bathing schedules/activities appropriate for consumer's specific disability/limitations?

- **Questions:** Are you satisfied with your bathing and grooming routines? Does anything frighten or scare you when you are bathed?

DRESSING

Putting on and taking off, fastening and unfastening garments and undergarments, special devices such as back or leg braces, corsets, elastic stockings/garments and artificial limbs or splints.

Rank 1: Independent: Able to put on, fasten and remove all clothing and devices without assistance. Clothes self appropriately for health and safety

- **Observations:** Appropriately dressed; clothing buttoned, zipped, laced; no difficulty with small hand movements as demonstrated by consumer's ability to sign application or manipulate bottles of medication
- **Questions:** Do you ever have any difficulty getting dressed (i.e., buttoning or zipping clothing, etc.)?

Rank 2: Able to dress self, but requires reminding or direction with clothing selection

- **Observations:** Appropriateness of dress for room temperature or clothing not bizarre (e.g., wearing underwear outside of clothing); clothing buttoned, zipped, laced; clothing relatively clean, mended if necessary, correct size for consumer; consumer is blind; is client alert and aware of appearance?
- **Questions:** Are there times when it seems just too much of a bother to get dressed for the day? Does anyone ever comment to you on how you are dressed? Are you warm enough/too warm? Could you use some help in getting your clothes organized for the day?

Rank 3: Unable to dress self completely, without the help of another person; e.g., tying shoes, buttoning, zipping, putting on hose or brace, etc.

- **Observations:** Are clothes correctly fastened? Does consumer apologize or seem embarrassed about state of dress? Does consumer ask you for any assistance? Is consumer disabled in dominant hand? Impaired range of motion, grasping, small hand movement; does consumer need special clothing?
- **Questions:** Are there any articles of clothing you have difficulty putting on or fastening? Do you need help with clothing items before you feel properly dressed? Do you need to use a special device in order to get dressed? Do you use Velcro fastening?

Rank 4: Unable to put on most clothing items by self. Without assistance would be inappropriately or inadequately clothed

- **Observations:** Range of motion and other movement impaired; dressed in bed clothes, robe and slippers rather than street clothes; does consumer appear too cold or too warm for room temperature? Does consumer seem willing to try to adapt to alternate methods of dressing?
- **Questions:** Do you feel unable to get out, or have people visit because you are unable to get adequately dressed? Do you ever feel too hot or too cold because you cannot put on or take off the necessary clothing to make you feel more comfortable? Has your health ever been affected because you have not been able to dress appropriately for the weather or temperature?

Rank 5: Unable to dress self at all. Requires complete assistance from another

- **Observations:** Is consumer capable of voluntary movement? Is consumer's clothing comfortable and clean? Does consumer appear satisfied with degree of dress (i.e., would consumer prefer a dress and shoes rather than a robe and slippers all of the time?) Can consumer support self without body support/device?

- **Questions:** How do you change your clothing? Do you ever feel too warmly or too coolly dressed? Is your clothing comfortable and clean enough? Do you get changed as often as you feel necessary?

BOWEL, BLADDER AND MENSTRUAL

Assisting person to and from, on and off toilet or commode and emptying commode, managing clothing and wiping and cleaning body after toileting, assistance with using and emptying bedpans, ostomy and/or catheter receptacles and urinals, application of diapers and disposable barrier pads. Menstrual care limited to external application of sanitary napkin and cleaning. (NOTE: Catheter insertion, ostomy irrigation and bowel program are evaluated as Paramedical Services. Getting to and from bathroom is evaluated as Mobility Inside.)

Rank 1: Independent: Able to manage bowel, bladder and menstrual care with no assistance from another person

- **Observations:** Consumer's movement unimpaired; has the consumer had colon cancer? Does the consumer wear a colostomy or ostomy bag? Did you see ostomy or colostomy bags?
- **Questions:** Do you need any help when you have to use the toilet? Do you also use a bedside commode, urinal, or bedpan? Do you have any problems getting to the bathroom on time?

Rank 2: Requires reminding or direction only

- **Observations:** Consumer seems disoriented or confused; urine smells detectable; furniture covered with barrier pads or plastic; adult diapers in the consumer's bedroom or bathroom; consumer takes diuretics such as Lasix; is the consumer's clothing stained indicating that there is an incontinence problem?
- **Questions:** In the past month, have you had difficulty getting to the toilet/commode on time? If yes, how often? Does someone remind you?

Rank 3: Requires minimal assistance with some activities but the constant presence of the provider is not necessary

- **Observations:** Moderate movement impairment needs a boost to transfer; or severe limitation of use of hands; female within appropriate age range for menstruation and no history of hysterectomy
- **Questions:** Do you have any problems using the bathroom or managing your clothes? Does anyone help you? If yes, what kind of assistance do you need and how often? Are you able to empty your urinal/commode (if used)? Do you have accidents? How often do the accidents occur? Are you able to cleanup after them? If worker believes consumer menstruates, do you menstruate? Regularly? How frequently? Do you manage by yourself?

Rank 4: Unable to carry out most activities without assistance

- **Observations:** Severe movement problems; consumer unable to transfer unassisted; consumer's or provider's statement as to the quantity or frequency of daily laundry; indication that "hand" laundry is done daily; is there a large amount of unwashed laundry with the odor of urine or fecal matter? Meds such as stool softeners
- **Questions:** Who helps you? How? Is (s)he available every time you need help? Do you need more help at certain times of the day/night?

Rank 5: Requires physical assistance in all areas of care

- **Observations:** Does the consumer have any voluntary movement? Consumer bedfast or chairbound; is (s)he able to make her/his needs known?
- **Questions:** Who helps you? What is your daily routine? Do you also need assistance with activities we classify as “Paramedical Services”?

TRANSFER

Moving from one sitting or lying position to another sitting or lying position; e.g., from bed to or from a wheelchair, or sofa, coming to a standing position and/or repositioning to prevent skin breakdown. (NOTE: If pressure sores have developed, the need for care of them is evaluated as a Paramedical Service).

Rank 1: Independent: Able to do all transfers safely without assistance from another person

- **Observations:** Movement unimpaired; able to get out of a chair unassisted when (s)he shows you the house
- **Questions:** Do you ever need a boost to get out of bed or out of the chair? When? How often?

Rank 2: Able to transfer but needs encouragement or direction

- **Observations:** Consumer seems confused and has trouble getting out of chair (probably more problematic in getting out of bed)
- **Questions:** Does anyone help you get out of bed in the morning? How does (s)he help you?

Rank 3: Requires some help from another person; e.g., routinely requires a boost or assistance with positioning

- **Observations:** Length of time it takes consumer to answer door; sounds heard as consumer comes to door. Consumer asks you for a boost when (s)he gets up to get medications, or is shaky when using assistive device; consumer obese and has a great deal of difficulty getting up; trapeze over consumer’s bed
- **Questions:** Do you always have difficulty getting out of a chair? Who helps you? How? How often? Do you also have trouble getting out of bed? What kind of help do you need? (Expressing interest in how consumer has solved one problem usually encourages them to tell you ways they have solved other problems in order to manage themselves.)

Rank 4: Unable to complete most transfers without physical assistance. Would be at risk if unassisted

- **Observations:** Consumer uses assistive device for mobility; consumer’s joints deformed from arthritis or some other disease; consumer wearing cast or brace; someone in house assists consumer to get up if consumer uses walker or consumer in wheelchair
- **Questions:** Who helps you? How? How often? Both in getting into and out of bed and in and out of chair/wheelchair? Do you need more help at certain times of the day/night?

Rank 5: Totally dependent upon another person for all transfers. Must be lifted or mechanically transferred

- **Observations:** Does consumer appear to be immobile? Does (s)he appear to be uncomfortable or in pain? Does (s)he experience skin breakdown? Does (s)he have any fears related to being moved? Is his/her position changed as often as necessary? Can consumer make needs known?
- **Questions:** Who is available to help you when you need to be moved? Do you feel they are

able to do so without causing you undue pain or discomfort? Is there anything that needs to be changed to make you more comfortable?

EATING

Reaching for, picking up, grasping utensil and cup; getting food on utensil, bringing food, utensil, cup to mouth, chewing, swallowing food and liquids, manipulating food on plate. Cleaning face and hands as necessary following a meal.

Rank 1: Independent: Able to feed self

- **Observations:** No impairment in grasp indicated when consumer signs application or handles medicine bottles; cup or glass next to consumer's chair; observe consumer take a drink
- **Questions:** Do you need any help eating? (Since deterioration usually occurs in a hierarchical manner and since feeding oneself is the last function to lose, questions may not be necessary if the consumer is able to dress herself and scores 1, 2, or 3 in Bowel and Bladder unless consumer seems mentally impaired.)

Rank 2: Able to feed self, but needs verbal assistance such as reminding or encouragement to eat

- **Observations:** Consumer appears depressed, despondent or disoriented; clothes seem large for consumer indicating possible recent weight loss; rotten food or no food in refrigerator, or a stockpile or Twinkies, only; no signs of cooking
- **Questions:** What have you eaten today? How many meals do you eat each day? Do you have trouble with a poor appetite? What is the difficulty? Are there times you forget to eat? Does it sometimes seem like it takes too much effort to eat? Do you have trouble deciding what to eat?

Rank 3: Assistance needed during the meal e.g., to apply assistive device, fetch beverage or push more food within reach, etc., but constant presence of another person not required

- **Observations:** Manual dexterity impaired, particularly of dominant hand; straws or cups with spill proof lids, consumer had difficulty shaking hands; severely limited eyesight
- **Questions:** Do you need help in feeding yourself? Do you need to use special utensils to feed yourself? Do you feel that you get enough to eat? Do you have difficulty reaching food on your plate or reaching your glass?

Rank 4: Able to feed self some foods, but cannot hold utensils, cups, glasses, etc., and requires constant presence of another person

- **Observations:** Food stains on clothing; shakiness of hands; deformity of hands with limitation in ability to grasp or hold; trays, towels, bibs
- **Questions:** Does someone help you eat? How? How often? Do you eat with the rest of the family? Can you feed yourself finger foods? Are you able to use a fork or spoon? Do you have difficulty chewing or swallowing? If so, how do you deal with the problem?

Rank 5: Unable to feed self at all and is totally dependent upon assistance from another person

- **Observations:** Consumer has no use of upper extremities; trays, towels, bibs, etc. observed

near consumer

- **Questions:** What is your daily routine for eating meals?

Rank 6: Is tube fed. All aspects of tube feeding are evaluated as a Paramedical Service.

RESPIRATION

Respiration is limited to non-medical services such as assistance with self-administration of oxygen and cleaning oxygen equipment and IPPB machines.

Rank 1: Does not use respirator or other oxygen equipment or able to use and clean independently

- **Observations:** Oxygen equipment present; consumer coughs or wheezes excessively or breathing is labored
- **Questions:** Are you able to clean and take care of the equipment yourself?

Rank 5: Needs help with self-administration and/or cleaning

- **Observations:** Same as above; when consumer ambulates, does (s)he have difficulty with breathing or is breathing laborious? See meds; consumer weakness, immobility in conjunction with breathing problems; referral from oxygen supplier indicating consumer is not taking care of equipment properly
- **Questions:** Are you able to clean and take care of the equipment yourself? If not, how does it get done? How often do you use the equipment? Have you had difficulty administering your own oxygen or using your breathing machine? (If yes, refer for paramedical). Who cleans equipment after you use it?

Rank 6: Needs Paramedical Service such as suctioning.

MENTAL FUNCTIONING

MEMORY

Recalling learned behaviors and information from distant and recent past.

Rank 1: No problem: Memory is clear; consumer is able to give you accurate information about his/her medical history; is able to talk appropriately about comments made earlier in the conversation; has good recall of past events

- **Observations:** Consumer's responses to your questions indicate that (s)he has good recall; knows his/her doctors' names; knows own phone number or the number of a close friend; is clear about sources of income and assets; knows who close relatives are and where they live. Consumer is mentally capable of following through on activities of daily living; has good social skills; thought process seems clear; is able to keep track during a conversation
- **Example:** An elderly women living alone in her home, responds quickly and confidently to your questions to establish her eligibility for IHSS and to determine her need for services. Consumer is reasonably organized; medications are in place, there are stamped bills in the mailbox, trash appears to be picked up regularly, has grocery list ready for IHSS provider
- **Questions:** Who is your doctor? What medicine do you take regularly? What is your address and telephone number? When were you born? Where were you born? What is the date today? How long have you lived in this house? Where did you live before you lived here? What serious illnesses or surgeries have you had? How long ago was each illness or surgery? Consumer is able to give you detailed information in response to your questions.

Rank 2: Memory loss is moderate or intermittent: Consumer shows evidence of some memory impairment, but not to the extent where (s)he is at risk; consumer needs occasional reminding to do routine tasks or help recalling past events

- **Observations:** Consumer appears forgetful and has some difficulty remembering names, dates, addresses, and telephone numbers. Consumer's attention span and concentration are faulty; consumer fidgets, frowns, etc., possibly indicating a struggle to recall; repeats statements and asks repetitive questions. Occasionally forgets to take his/her medication or cannot recall when (s)he last took medication, but this problem is corrected with the use of a Medi-Set (pill distribution box) set up by someone else. May become bewildered or appear overwhelmed when asked about details; recall process may aggravate mental confusion or cause intermittent memory loss. Becomes moderately confused when daily routine is altered
- **Example:** Elderly man has to be prompted occasionally by his wife when he tried to respond to your questions. Apologizes for or tries to conceal memory lapses
- **Questions:** What year were you born? How old are you now? How old were you when your first child was born? What medicines do you take? Tell me what you usually do during the day. Who phones or comes to see you often? What do you have to eat for dinner tonight?

Rank 5: Severe memory deficit: Consumer forgets to start or finish activities of daily living which are important to his/her health and/or safety. Cannot maintain much continuity of thought in conversation with you

- **Observations:** Consumer has blank or benign look on his/her face most of the time. Is continually placing and replacing objects in the room to avoid answering your questions. Consumer gives inappropriate responses to questions; voice and/or train of thought trails off in middle of conversations; starts an activity and forgets to finish it. Consumer consistently forgets to take his/her medications or takes them inappropriately, even with a Medi-Set. Has a history of leaving stove burners on or water running in the sink or tub to overflow. Cannot remember when (s)he ate last or what (s)he ate. Is unable to remember names of close relatives; may have loss of verbal ability; impaired intellectually, displays abnormal and potentially dangerous behavior
- **Example:** Middle-aged man suffering from Alzheimer's disease is totally unable to respond to your questions; becomes very agitated for no good reason; arises from chair as if to leave room and stares in bewilderment; needs to be led back to his chair. He seems unconcerned with events in daily life and cannot articulate his need for service; daily routine follows a set, rigid pattern; consumer relates to situation on a superficial basis
- **Questions:** What are the names and relationships of your closest relatives? Did you eat breakfast today? What did you eat? Can you tell me what I'm holding in my hand? How old are you? What is your birth date? (posed to housemate) What happens when the consumer is left alone? Does (s)he remember any events from the previous day, hour or minute? Does (s)he remember who you are? Does (s)he remember how to operate the stove, shave himself, or perform other tasks safely?

ORIENTATION

Awareness of time, place, self and other individuals in one's environment.

Rank 1: No problem: Orientation is clear. Consumer is aware of where (s)he is and can give you reliable information when questioned about activities of daily living, family, etc.; is aware of passage of time during the day

- **Observations:** Consumer appears comfortable and familiar with his/her surroundings. Consumer makes and keeps good eye contact with you; facial expression is alert and affect is appropriate to the situation; in spontaneous and direct. Shows interest in maintaining a good personal appearance. Consumer is obviously in touch with reality; is aware of time and place; readily responds to questions about living arrangement, family, etc.; is fully aware of reason for your visit. If consumer is physically able to leave home unassisted, can find his/her way back without getting lost and can get around using public transportation
- **Example:** Consumer is ready and waiting for your visit; initiates social amenities such as offering coffee, a chair to sit down on, etc. Introduces family members or is able to identify family pictures when asked. Has the documents ready which you asked her to locate
- **Questions:** Do you have relatives living close by? Why are you asking for help at this time? How have you managed to care for yourself until now? Do you have someone who helps around the home?

Rank 2: Occasional disorientation and confusion apparent but does not put self at risk: Consumer has general awareness of time of day; is able to provide limited information about family, friends, age, daily routine, etc.

- **Observations:** Consumer may appear disheveled and the surroundings, chaotic. Objects are misplaced or located in inappropriate places; moldy food in and out of kitchen. Does not notice that the home is overheated or under-heated until you mention it. Consumer appears to be less confused in familiar surroundings and with a few close friends. Consumer is able to maintain only marginal or intermittent levels of social interaction. Consumer is able to provide some information but is occasionally confused and vague; not always aware of time, surroundings and people; is able to respond when redirected or reminded
- **Example:** Twice in the past year consumer has called her daughter at 2:00am and was not aware that it was the middle of the night. When told what time it was, consumer apologized and went back to bed. When you enter her apartment, elderly woman asks, "Why are you here today? You said you'd be here Tuesday." You respond, "This is Tuesday." Consumer seems unprepared for your visit and has difficulty settling down for interview; participates with some difficulty. Is not comfortable outside of his/her immediate environment and rarely ventures out. Mail may be left unopened occasionally, clothing and some perishable food items are not properly stored
- **Questions:** What day is today? How many rooms do you have in your home? Where is the closest grocery store? Do you know who I am and why I am here? Do you go out alone? Do you ever get lost when you go out of the house alone? Do you know the name of the bus you take when you go to the store and where the bus stop is to go home? What month, year, season, holiday, etc.?

Rank 5: Severe disorientation which puts consumer at risk: wanders off; lacks awareness or concern for safety or well-being; unable to identify significant others or relate safely to environment or situation; no sense of time of day

- **Observations:** Shuffles aimlessly throughout house. May exhibit inappropriate behaviors such as giggling, making comments that are irrelevant to the conservation. Handles objects carelessly. Appears unkempt, personal hygiene is poor; manner of dress is inappropriate or bizarre articles of clothing. When social worked attempted to shake hand, consumer tried to bite social worker's hand. Consumer is very confused, unaware of time, place, and/or individuals. Goes to the mailbox and cannot find way back to the apartment. Does not recognize apartment manager when he tries to help the consumer find her way back to the apartment and consumer becomes highly agitated. Consumer appears to be disoriented and may experience hallucinations and display a dazed and confused state of mind. Unable to answer simple questions appropriately; sleep-wake cycle may be abnormal; confuses son with dead husband; emotional instability may be present
- **Example:** Family member or friend must answer door as consumer is unable to maneuver in home without wandering. Must be directed to chair. Evidences no awareness of purpose of visit. Unable to concentrate. He either does not respond to questions or speaks unintelligibly
- **Questions:** What is your name? Where do you live? What is the date today? What year is it? Where are you? Where are you going? (Consumer is unable to respond or responds inappropriately.) (posed to consumer's housemate) What is the nature of ___'s mental problem? What can he do for himself? What does he do if he is left alone?

JUDGMENT

Making decisions so as not to put self or property in danger; safety around stove. Capacity to respond to changes in the environment, e.g., fire, cold house. Understands alternatives and risks involved and accepts consequences of decisions.

Rank 1: Judgment unimpaired: Able to evaluate environmental cues and respond appropriately

- **Observations:** Home is properly maintained, and in safe repair. Responses show decision making ability intact. Dresses appropriately for the weather. Able to form correct conclusions from knowledge acquired through experience; capable of making independent decisions; able to interact with others
- **Example:** Consumer takes pride in managing own affairs and does so appropriately. Has list of numbers to call in case of emergency. Takes measures to guard safety such as locking doors at night, not allowing strangers into home, etc.
- **Questions:** Do you have a list of numbers to call in case of an emergency? Do you have friends or family who could help out in a crisis situation? What would you do if your provider is unable to come to work one day?

Rank 2: Judgment mildly impaired: shows lack of ability to plan for self; has difficulty deciding between alternatives but is amenable to advice; social judgment is poor

- **Observations:** Home in some disrepair (leaking faucets, broken appliances, inadequate lighting, etc.) Debris has been allowed to accumulate in walk-way areas. Foodstuffs may be of poor nutritional value. Unable to recognize that there are alternatives or select between them; unable to plan or foresee consequences of decisions. May not be capable of making decisions without advice from another; is able to understand options, when explained, and make correct choices; knows enough to turn stove and heat on and off
- **Example:** Consumer wastes money on useless items while allowing needed repairs to go unattended. “Makes do” with condition of home even if inconvenient. May be a “collector”- has difficulty throwing anything out, even though access through home is limited. Can’t decide which provider she wants. Grocery list to provider contains mostly junk food. Stopped homebound meals when she decided they weren’t tasty rather than add salt. Refuses to use walker or cane
- **Questions:** Who would you call in case of emergency? (list is incomplete, but contains some helpful numbers.) If someone you did not know came to your door at night, what would you do? What are you able to do for yourself? Do you need anyone to help you? Who would you depend on to assist you if you needed a household repair done such as if your heater did not work?

Rank 5: Judgment severely impaired: fails to make decisions or makes decisions without regard to safety or well-being

- **Observations:** Safety hazards are evident- clothing has burn holes; faulty wiring, leaking gas, burned cookware, etc. Utilities may be shut off. Food supply is inadequate or inedible. If pet owner, animal feces in home. Consumer obviously unaware of dangerous situations; not self-direction; mentally unable to engage in activities of daily living. Goes outside with no clothing on. Four times this week, neighbors saw smoke from apartment, entered and extinguished fires on stove. Someone from the community calls to report that the consumer is defecating or urinating on the front yard. Consumer cannot decide to eat, dress, or take medications. Consumer seems preoccupied, confused or frightened; is unaware or too frail or feeble to make decisions to maintain self safely at home. Drinking spoiled milk. Taking a shower with clothes on.
- **Example:** Has open access to home to anyone who approaches. Consumer seems unaffected by stench or odors due to garbage, feces, urine etc. Exhibits no concern over obvious safety hazards- debris piled on stove, papers scattered near heater, etc. Injuries such as burns go unattended. Consumer has recurrently in the past year started dinner, fell asleep, and awoke to a smoke filled kitchen
- **Questions:** What would you do if you saw something on fire in your house? If you needed to get to the doctor what would you do? (Ask housemate) What happens when __ is left alone? Can (s)he recognize situations which would lead to danger? Is (s)he capable of making rational decisions?

Authorization Trends

Impact of Authorization Trends

For prioritizing Training Academy subjects, CMIPS data was analyzed to identify authorization trends that appear problematic. Analysis focused on "Total Need," before adjusting (prorating) for shared living arrangements and before taking into consideration alternative resources or refused services. The reason this column was used is that it is the area where the Social Worker has the most discretion. The Adjustment column is most dependent on the demographics of the county and the consumer's living arrangement. The Alternative Resource column is most dependent on the county's long term care resources.

The highest number of hours of total need in the state is for Protective Supervision. That is not surprising, because total need for people needing Protective Supervision should be 168 hours per week (24 hours per day, 7 days per week). However, for the most part, now that Protective Supervision is a PCSP-funded service, authorization of Protective Supervision is like a toggle switch – either authorize 283 hours per month or nothing. And only 4.1% of the statewide caseload has a total need for Protective Supervision. The regulation rewrite efforts will clarify Protective supervision and there will soon be a state-mandated medical form for Protective Supervision, so comments in this document focus on the rest of the tasks.

The ranking of hours of total need for the State is below. To have an accurate comparison, hours for Domestic and Heavy Cleaning were converted to weekly values:

Task	Hours per Week	% of Hours
Meal Preparation	2,114,680	26.4%
Meal Cleanup	871,812	10.9%
Bathing, Oral Hygiene and Grooming	831,013	10.4%
Bowel and Bladder	573,569	7.2%
Dressing	451,526	5.6%
Domestic	446,448	5.6%
Laundry	414,224	5.2%
Rubbing Skin and Repositioning	365,018	4.6%
Shopping	332,880	4.2%
Ambulation	316,232	4.0%
Feeding	246,584	3.1%
Moving In/Out of Bed…	217,115	2.7%
Medical Accompaniment	191,882	2.4%
Paramedical Services	176,979	2.2%
Errands	168,776	2.1%
Prosthesis	165,157	2.1%
Bed Bath	58,877	0.7%
Respiration	38,375	0.5%
Accompaniment to Alt. Resource	11,279	0.1%
Menstrual Care	7,454	0.1%
Removal of Ice and Snow	316	0.0%
Teaching and Demonstration	109	0.0%
Heavy Cleaning	44	0.0%
Total	**8,000,350**	

Another way to look at the use of IHSS is to evaluate the proportion of cases that have a Total Need in CMIPS (called "Saturation" below). The more frequently Social Workers make decisions about a task, the more it matters that the decision process is consistent throughout the State. Below is the ranking of tasks by proportion of cases that have a Total Need:

Task	Hours per Week	Saturation
Domestic	446,448	98.0%
Laundry	414,224	97.6%
Shopping	332,880	97.0%
Errands	168,776	96.7%
Meal Cleanup	871,812	95.7%
Meal Preparation	2,114,680	95.1%
Medical Accompaniment	191,882	87.6%
Bathing, Oral Hygiene and Grooming	831,013	87.6%
Dressing	451,526	75.5%
Care and Assistance with Prosthesis	165,157	54.3%
Bowel and Bladder	573,569	48.8%
Rubbing Skin and Repositioning	365,018	48.4%
Ambulation	316,232	47.0%
Moving In/Out of Bed…	217,115	46.2%
Feeding	246,584	18.6%
Paramedical	176,979	8.4%
Bed Bath	58,877	6.8%
Respiration	38,375	6.0%
Menstrual Care	7,454	3.5%
Accompaniment to Alt. Resources	11,279	2.1%
Removal of Ice and Snow	316	0.0%
Heavy Cleaning	44	0.0%
Teaching and Demonstration	109	0.0%
Total	8,000,350	

Looking at the two lists (combining the rank of the hours and the proportion), we can identify tasks that seem to be near the top of both lists. Though data listed includes all clients in E, I and L status, when comparing authorization trends to Functional Rankings in the associated function, only cases new to IHSS in their first authorization period were used:

- **Meal Preparation** and **Meal Cleanup** are at the top of the list. Coincidentally, CMIPS authorization data indicates that these are two tasks where workers tend to determine the same need, regardless of the Functional Ranking.
- Within the top 10, there's **Laundry** (rank 3), **Shopping** (rank 5), and **Domestic** (rank 6). Because we already have Time Task guidelines for those tasks, authorization data trend analysis on those tasks was not done.
- The other three tasks that are in the top of the hour/proportion ranking are **Bathing-Oral Hygiene & Grooming**, **Dressing** and **Bowel and Bladder**.

Below is the entire list of task-rank. The task rank is the sum of the rank of the hours of total need for the task and its saturation:

Task	Rank
Meal Preparation	7
Meal Cleanup	7
Laundry	9
Bathing, Oral Hygiene and Grooming	11
Shopping	12
Domestic	14
Dressing	14
Bowel and Bladder	15
Errands	20
Rubbing Skin and Repositioning	20
Medical Accompaniment	20
Paramedical	20
Ambulation	23
Feeding	26
Moving In/Out of Bed…	26
Care and Assistance with Prosthesis	26
Bed Bath	34
Respiration	36
Menstrual Care	39
Accompaniment to Alt. Resources	39
Removal of Ice and Snow	42
Teaching and Demonstration	43
Heavy Cleaning	45

Authorization Trends

CMIPS data from the month of February 2005 of all consumers who are authorized IHSS and who were on their first CMIPS assessment was used for the data analysis below. For the most part, that meant that they were first granted between March 1, 2004 and February 28, 2005. This is important because many workers tend not to change the consumer's functional ranking when the consumer's functioning changes. Therefore, the likelihood is that the most accurate reflection of the consumer's functioning is contained in the initial assessment.

Correlations were evaluated between functional ranking and Total Need for the associated task(s). Total Need was used because that is the portion of the authorization that should be independent of the consumer's shared living arrangement and of his/her use of an alternative resource or refusal to accept assistance in a task the Social Worker believes is needed. Of course, one cannot conclude decisively when there are discrepancies between the functional ranking and total need, whether the problem is with the determination of functioning or of hours. There is no clear standard as to what the relationship between the functional ranking and the total need should be, but it should vary between ranks. That is, it may take longer to assist a person who is ranked a 4 in certain ranks than it would to help one who is a rank of 5. However, if a person ranks a 4, s/he should participate in the completion of the task to his/her ability in order to maintain functioning, even if it takes longer to complete with the consumer's participation.

Another thing evaluated in CMIPS data is the proportion of those new consumers who are determined to have a need for hours in specified tasks. The level of variance between counties may be a result of one or more factors:

- differing thresholds for being granted IHSS (determination of the potential of placement without IHSS)
- differing standards when determining whether a consumer can perform a function independently
- differing attitudes about placement in a Skilled Nursing Facility in lieu of IHSS
- differing demographics of the potential IHSS-consumer population because of medical centers, universities, resources for people with disabilities.

CMIPS does not provide information to see if the differences are based on different consumer demographics or inequitable assessment standards.

Meal Preparation

CMIPS data shows that, excluding Protective Supervision, the greatest number of IHSS hours are going to Meal Preparation (more than a quarter of the hours). And it's unusual for someone to be granted IHSS without Meal Preparation (95% of all IHSS consumers in the State are authorized this task). The most striking issue about Meal Preparation is that, regardless of the functional ranking, almost all consumers have the need for 7 hours a week. That is particularly troubling because the definitions of ranks for Cooking are slightly different than the definitions for the rest of the functions. Specifically:

Rank 1 means the consumer is independent (same as for the other functions)
Rank 2 means, "Needs only reminding or guidance in menu planning, meal preparation and/or cleanup" (again this rank follows the same pattern as others)
Rank 3 means, "Requires another person to prepare and cleanup main meal(s) on a less than daily basis; can reheat food prepared by someone else, can prepare simple meals and/or needs help with cleanup on a less than daily basis."
Rank 4 means, "Requires another person to prepare and cleanup main meal(s) on a daily basis."
Rank 5 means, "Totally dependent on another person to prepare and cleanup all meals."
Rank 6 means, "Is tube-fed. [i.e., all ingestion is through NG or similar tube – no supplemental eating through the mouth.] All aspects of tube feeding are evaluated as a Paramedical Service."

The rank definitions follow the same pattern, but are more specific. There are two glaring "errors" in the comparison between the functional ranking for Cooking and the total need hours per week for Meal Preparation.

1. The mode (most common number of hours of Total Need) for Meal Preparation is 7.00 hours per week. 3 of every 5 consumers have that Total Need, regardless of the number of meals the consumer needs assistance with. How can the mode for most people who can make their own breakfast and lunch (and maybe a snack) and can reheat meals if someone comes in a couple of times a week and makes main meals ahead for the consumer to reheat be the same 7 hours as those who can't even pour themselves a bowl of cereal?
2. If all Meal Preparation and Meal Cleanup for a person who is tube-fed exclusively should be authorized as a Paramedical Service, then no one with a functional rank of 6 in Cooking should be authorized any time in Meal Preparation or Meal Cleanup. However, consumers who are both tube fed and ingest some food through the mouth should be ranked something other than 6 in the function of Cooking, even though they are also tube fed.

The following is a chart that shows the data from which the conclusions were taken.

	% at Rank	Mean	Median	Mode	% at Mode
Rank 2	0.6%	4.36	4.00	7.00	
Rank 3	24.3%	5.18	5.25	7.00	
Rank 4	27.2%	6.19	7.00	7.00	
Rank 5	47.7%	6.78	7.00	7.00	
Rank 6	2.0%	5.99	7.00	7.00	
All	95.1%	6.53	7.00	7.00	60.7%

While Statewide, 92.7% of all "new" consumers are determined to have a Total Need for Meal Preparation, the range is between 68.4% and 100.0%. The median is 90.5%. That means that there is a slightly lower proportion of consumers from smaller counties to have a need for Meal Preparation than larger ones, though that pattern certainly has significant inconsistencies. The range, though, shows that either the people who receive IHSS differ between counties (though there is a single definition of eligibility for IHSS) or the assessment practices differ between counties leading to inequity of service

levels between counties. The data also shows that as time goes on, as with other tasks, more consumers are determined to have a Total Need for Meal Preparation than when they were first granted because 95.7% of the overall IHSS caseload has a Total Need for Meal Preparation.

Meal Cleanup

Meal Cleanup accounts for about 10% of the IHSS hours. For this task, the mean and median seem to increase as the functional index rank increases. However, the mode is 3 ½ hours per week for the ranks of 2, 3, and 4, but decreases to 2 hours and 20 minutes for the rank of 5 and further to 1 hour and 45 minutes for the rank of 6. As above, if the person is a rank of 6, all their meal preparation should be authorized in Paramedical Services. But it is illogical for there to be a downward trend for washing dishes, etc. for a person who can't even rinse a glass. Another issue to consider when authorizing Meal Cleanup is how frequently the task is done and what's washed. For example, it probably takes longer to cleanup after the main meal, unless the main meal was leftovers reheated in the microwave on the plate the consumer ate from. Questions to consider are how many days per week the provider washes dishes, whether one or two day's dishes are rinsed and stacked in the sink, waiting for the provider to wash them, etc. The level of consistency in Total Need for Meal Cleanup (about 1 in 4) is not as bad as Meal Preparation (3 in 5), the most consistent mode indicates a clear problem.

Below is a chart containing the data I used to draw my conclusions:

	% at Rank	Mean	Median	Mode	% at Mode
Rank 2	0.8%	2.05	1.75	3.50	
Rank 3	24.6%	2.30	2.00	3.50	
Rank 4	27.0%	2.56	2.33	3.50	
Rank 5	47.4%	2.65	2.45	2.33	
Rank 6	20.0%	2.44	2.33	1.75	
All	95.7%	2.67	2.33	3.50	23.5%

Approximately the same number of consumers need Meal Cleanup as Meal Preparation. That is logical; the activities involved in washing dishes and pots and pans are similar to those needed in cooking: some level of endurance, often standing; manual dexterity; lifting; getting hands wet, and the like. 93.2% of all new consumers need Meal Cleanup; slightly more (95.1%) of all IHSS consumers do. Once again, however, the range of percentage by county runs from a low of 62.5% to a high of 100% with a median of 89.6%. All consumers were authorized Meal Cleanup in 3 counties.

Bathing, Oral Hygiene and Grooming

The most common personal care task authorized is Bathing. CMIPS data shows that the hours increase as the functional rank increases in the mean and median. That trend in hours seems logical. However, once again, the mode shows too much consistency, being 3 ½ hours per week, no matter how much help the consumer needs. For the rank of 3, the provider would help the consumer in and out of the shower/tub, and would need to be within earshot in case the consumer needed help, but the consumer is pretty capable of washing him/herself unattended. The provider may shampoo the consumer,

but the consumer can do a proportion of his/her bathing and grooming without assistance. That would differ from the rank of 4 where the provider stays with the consumer, so the provider couldn't multi-task during the consumer's bathing. In a rank of 5, the provider would do all the bathing and grooming. Another issue in authorizing bathing is to determine the frequency of bathing. Many older consumers don't bathe daily, unless they are incontinent. Because 3 ½ is divisible by 7, it seems likely that the common practice is to figure a half hour for bathing a day. Yet few consumers have daily care, unless provided by a housemate or family member.

Below again is a chart of the statistics used to draw the conclusions above:

	% at Rank	Mean	Median	Mode	% at Mode
Rank 2	3.5%	1.16	1.00	1.00	
Rank 3	67.7%	1.83	1.75	3.50	
Rank 4	21.8%	2.83	2.75	3.50	
Rank 5	7.0%	3.45	3.34	3.50	
All	87.6%	2.78	1.96	3.50	7.2%

81.4% of the new consumers had a need for Bathing, Oral Hygiene and Grooming. That compares to 87.6% of all consumers. Once again, there is a likelihood that consumers' needs increase over time. Again, there is a wide variance in the proportion of consumers who were assessed to need Bathing, Oral Hygiene and Grooming from 50% to 97.3%. The median is 78.3%. 3 counties had less than 60% of their caseload needing Bathing; 6 counties in the 60-70% range; 22 counties in the 70-80% range; 19 counties in the 80-90% range and 8 in the 90+% range. Once again, these statistics raise questions about service equity.

Bowel and Bladder

Bowel and Bladder care is the first of all the tasks described where the mean, median and mode all increase as the functional ranking increases. However, the increments of increase, particularly in the median and mode, look disconcerting. Because the mean doesn't represent any actual consumers, it looks like the trend of counties is to authorize time in 15 minute increments. The only mean or median that's not an increment of 15 minutes a day, 7 days a week is the rank of 2, reminding. The rank of 3 is 15 minutes a day; rank of 4 is ½ hour a day; and rank of 5 has a median of 45 minutes a day and a mode of an hour a day. The question is: how often does the consumer need/get help urinating? Having a bowel movement? How long does assistance with each take? How often does the provider empty and wash the commode, urinal, etc.? How often does the provider change diapers? How long does each take? Is the consumer able to change his/her own diapers? Is the consumer incontinent? Of bowel? Of bladder? How often? Specific times of the day? Is it an issue of impaired mobility? Would this be avoided with a commode?

Below, again are the statistics I used to form my comments:

	% at Rank	Mean	Median	Mode	% at Mode
Rank 2	3.9%	1.36	1.00	0.50	
Rank 3	64.5%	2.15	1.75	1.75	
Rank 4	20.8%	4.19	3.50	3.50	
Rank 5	10.7%	5.77	5.25	7.00	
All	48.8%	3.45	2.33	3.50	8.5%

10% of all new cases have an assessed need for Bowel and Bladder care. That compares to 48.8% of all consumers. As with other tasks discussed above, we would expect there to be an increase of need over time, due to functional deterioration. However, this amount of difference is so significant that it seems to be an area that needs particular attention. We know that it's difficult for people to be at ease discussing toileting behavior. And it is sometimes humiliating for people to admit to incontinence. Some Social Workers may find it awkward to discuss toileting. For a consumer to be forthcoming with information about his/her toileting habits, needs, impairments, Social Workers must be unembarrassed by the subject and must be able to put the applicant at ease in discussing this task.

Assessment Tools

SPECIAL INSERT

Doing the Interview: How to Really Ask Those Questions and Enjoy it

Colleen King

September 1990

An edited version of a presentation given at "Assessment Revisited: Practical Approaches to Assessing the Elderly." A conference presented by the University of Minnesota Long-Term Care DECISIONS Resource Center, Minneapolis, Minnesota.

Colleen King presented this paper and additional insights at "Assessment Revisited: Practical Approaches to Assessing the Elderly," the Center conference held in September in Minneapolis.

Through years of experience in both supervising and training interviewers and through my own experience as an interviewer I have developed a style of interviewing I call, *conversations with a purpose.* This style of interviewing is conversational, relaxed, but structured within the boundaries of appropriate interviewing. Even in the most open-ended type of assessment there will be boundaries of correctness that each individual administrating the tool must stay within. I have tried to develop a style that will insure that the viability of the tool will not be compromised, allow you to stay within the boundaries of the tool, and make the assessment workable and enjoyable for the individual administrating the tool.

The comprehensive assessment interview can be a valuable tool in assessing the needs of older people. If done correctly the assessment can be an enjoyable and rewarding experience for both the client and the assessor. If done incorrectly the assessment can be biased, frustrating, and a waste of everyone's valuable time. In the next few pages I would like to challenge you to an enjoyable experience. Conversations with older people are never boring. You should have confidence in the assessment tool and know the information you collect will help you provide for the needs of the individuals you desire to help.

I would like to talk about the most common mistakes and how to correct them. The most common mistakes made in any kind of assessment interview, either interviews with fixed questions or more open-ended interviews, are:

- Failure to ask the questions on the tool.
- Not spending time to develop rapport with the client.
- Bias or leading the client.
- Inappropriate probing.
- Avoiding difficult situations.

The responsibility of the assessment lies in your hands. With proper training, a better understanding of the tool, and support from peers, your job can be worth your time.

ASK THE QUESTIONS

The key to your successful comprehensive assessment of a client is knowing and understanding your assessment tool. The assessment tool was designed with the purpose of permitting a fuller and better understanding of the care needs of the older person. If your assessment is done correctly you should be able to:

- determine eligibility of the client.
- better respect the rights of the client.
- design a care plan that will fit the needs of the client.
- become more familiar with future needs of the client.
- provide information to planners that will allow them to more accurately determine the needs on a community basis.

For the client's sake, the assessment tool should be taken seriously. If it's not worth your time to ask the questions correctly, it is not worth the client's time to try to answer the questions honestly. Without the assessment tool you are not going to get accurate data. You may think you know how I feel, but unless you ask me you are only guessing. If I have recently lost a spouse and you skip the questions dealing with mood and outlook because you assume you know the answers, you have lost valuable information about me. You do not know if I am handling the situation within the normal range of grief, or if I am not facing the

situation and may need help. You just assume I am depressed. Depression, sadness and grief are very different. It is far better to learn how to talk to the grieving client and how to ask questions in difficult situations than to answer for the client. To design a care plan on guessing is not fair to the client. These tools have been developed to help you meet the needs of the client.

A common problem is not asking the questions when they are embarrassing to the assessor. The interviewer is often uncomfortable talking about incontinence or income or both. Older people don't mind describing toileting issues if discussed matter-of-factly. If questions are handled in a respectful manner people will not mind discussing these issues. If you have developed rapport with the client early on you will not feel as embarrasssed. The client will understand that what you are doing is important and you will feel confidence in the rapport established. The purpose of the comprehensive assessment is not to embarrass, but to provide a care plan. Incontinence is a common problem with older people and is not embarrassing. If an individual becomes embarrassed by questions it is your responsibility to comfort that person.. Inform them, "I talk to a variety of people in many different situations and all questions are important in determining a care plan. All questions may not be relevant to you or your situation, but they are all an important part of the assessment."

Before a comprehensive assessment is done each assessor should know:

- What each question means, and how to reword the question to adapt to odd or difficult situations.
- What are the boundaries of each question? When would I be leading or biasing; how much do I help the client understand the question? In the ADL's usually there is a definition of dressing, and eating, and you must not neglect giving the full elements of this definition. You must know what to do when the client says, "I can do everything but button the back of my dress." An example of more strict boundaries might be in the mental status questions where often you are instructed not to change or alter the questions at all.
- How to answer questions to reassure the client of the worth and value of the assessment.

If you do not have a working knowledge of the tool you should ask for help. If you do not believe in and value the tool, you should talk to someone who has confidence in the tool. There should be someone available to assist you. If you understand what you are doing and have confidence in what you are doing, your comprehensive assessments will be enjoyable and valuable. Before you use the assessment tool:

- Role play with another employee.
- Make notes of difficult questions and how to handle them.
- Be prepared to answer questions about the tool.
- Know how to handle difficult situations.

SPEND TIME TO DEVELOP RAPPORT

After you have a working knowledge and confidence in your tool the next thing to learn is developing rapport with the client. The time you spend in the beginning to develop rapport can make or break an assessment. If the client feels comfortable with you, he/she will speak more openly with you. Spending time to develop rapport can make the interview go more quickly, you will gather more valuable information, and the conversation will be more enjoyable. You develop rapport by:

- Speaking in a conversational tone.
- Spending time talking about something other than the assessment (small talk).

reassuring clients that this is important and worth their time. The information will be used to prepare a care plan that fits their needs.

- Not being afraid to answer questions. Approach questions as an opportunity to explain further, not as an obstacle to overcome.
- Listening to the client and making a mental note of speech patterns. This will help you pace the assessment to the characteristics of the client. It is important early on to note whether the client is talkative or quiet.
- Letting clients know you are enjoying talking with them; it will help them relax.
- Observing the client's behavior in the presence of others. If there are other family members in the room, this will give you an opportunity to view how openly the client speaks in front of others.
- Spending some time talking about the assessment before you begin. Tell the client the type of questions you will be asking and why, i.e. "I will ask you some general questions about activities you may be involved in. This will help us work together to figure out your needs and how we can be helpful to you."
- Always being professional, but not being afraid to enjoy yourself. You can laugh and be relaxed while doing your job. If you are relaxed the client will know that they too can be relaxed.

The time you spend developing rapport with the client will help you better understand the client. This knowledge of the client will help you direct the conversation, know when to probe more, give you an idea of how talkative the client is and how much time the assessment will take. Social workers and nurses are trained to make people feel comfortable and are excellent interviewers. Do not become paralyzed by the assessment form or forget the skills you already have. Integrate the skills you have with the assessment tool. Do not be overwelmed by the assessment tool and forget the sensitive listening skills you have. Set the assessment tool aside when needed and listen to the client. If you have developed rapport early on, this will come naturally.

AVOIDING BIAS

This is an area where most professionals will err. You know the issues so well, and you are so familiar with the needs of older people that you are probably right more than you are wrong when you guess or assume. The problem is not when you are right, but when you are wrong. The assessment tool was not designed for the professional to guess, but for the professional to ask and find out what the client will answer. A bias is any influence that changes an answer or an opinion from what it might have been without that influence. It is important to be aware of your own bias and how that would conflict with the assessment. Once you say to the client, "so what you are trying to say is," you have given your opinion and biased the assessment.

It is important to be aware of interviewing errors. It is easy to relax your objective attitude and thus bias responses. To avoid influencing or biasing, follow these rules:

- DO NOT express your own opinions or how you think the client should respond (i.e. "I think everyone should have physical therapy"). Clients will change their answers to please you or change their answer to what you believe to be the correct answer. Try to reassure the client that we really do want their opinions. We are interested in what they experience or feel about a certain situation. The whole purpose of a comprehensive assessment is defeated when you answer for a client, lead the client or bias the client's responses.
- DO NOT suggest answers even if the client wants your help. Help the client sort out their opinions or responses; don't give them the answer. Repeat the question, read it through slowly, pause, and tell the client to "take a moment and think about it." If you

take your time and do not rush the client, you will be less likely to suggest an answer. The client will appreciate your kindness and patience.

- DO NOT use leading probes. Any probe which suggests an answer is a leading probe and can bias the interview. Do not make the assumption that you know what the client is talking about; let the client explain. Don't lead the client to an answer or response you think seems right or fits their situation.
- DO NOT rush the client. Some people need time to sort out their responses. If the clients are not answering, do not take this as if they are objecting to the assessment, but allow them a moment to think through their answers. If you jump in too soon, you will try to answer for them. You may think the client does not understand or does not like the question when he/she is just trying to think of the answers. Do not appear impatient; appear interested. You can acknowledge that "it is sometimes difficult to decide these answers."

The obvious and most unfair way to bias the assessment is not to ask the questions. ASK THE QUESTIONS: give the clients the opportunity to tell you their opinion, responses, and what type of care they do want or don't want. The only way you will find this out is if you let the client tell you. The last ten people you talked to might have felt a certain way, but this next person is different. If you don't ask the questions you will never know. It is like voting. If fifteen individuals voted "yes" they want their taxes increased, you would hardly assume I too would vote "yes" and not even ask me? Ask me; I have a right to my opinions!

HOW TO PROBE

One of the most common mistakes in probing is to use an inappropriate probe, that is, a probe that either leads or would bias the interview. Correct probing is probably the most difficult part of the comprehensive assessment. Inappropriate probing will occur when the assessor is having difficulty obtaining a response from the client or when a question is asked and the assessor does not know how to answer it. A correct probe is a prompt which encourages further conversation without biasing the response. The probes you would use most often are:

- Probing for correctness.
- Probing for clarity.
- Probing for completeness.

Probing for correctness is used where you want the client to answer within a category or within set responses. The best way to probe for correctness is:

- Repeat the question and the responses. When doing this, change your tone or where you pause, and it may sound different; speak slowly; and look up at the client. Try to add small talk before you repeat the question.
- Explain to the client that you are restricted by these responses. Use probes like, "if you had to choose, which one would you choose," or, "taking everything into consideration, which one would be closest to you." Always avoid probes that lead to a positive or negative end of the scale. If the client has been very ill and you ask, "Is your health excellent, good, fair or poor?" You would never probe with, "So is your health fair or poor?" Always give the client the opportunity to reflect on the full range of answers. It would be better to say, "Let me read the choices again, they are: excellent, good, fair, or poor."

If you probe in a pleasant, conversational manner your probes will not seem repetitive or obtrusive. Keep telling the client how important it is to get their views and what they feel are their needs.

Probing for clarity often entails asking the clients for a more specific response or an explanation to their answers. The client has answered your question, but you need to clarify what is meant by that answer. Always try to help the client when probing for clarity; let the client know what you don't understand and what you need clarified. The most common probes for clarity are:

- "What do you mean by that? You said that you were tired a lot; tell me what that means to you." You want the client to open up and talk to you. Does tired mean bored or sleepy, or you can't get out of the chair to answer the telephone when it rings. If the client doesn't explain tired to you, it is left to your interpretation of what tired means to you. It is much better to find out what it means to that client.
- "Could you explain that, tell me more about that?" If you are interested in what the client is saying and the conversation is going smoothly, asking the client to explain or tell you more will seem natural.
- "I'm not sure I understand." Simply direct the client's comments by letting him/her know what you do not understand.

On many mental health batteries, the answers do require probing. For example, you ask, "Do you see things that others don't see?" and the client answers, "Yes." Before deciding to refer to a mental health specialist, a probe "Can you tell me more about what you see?" would be helpful. The client might say, "I've always been intuitive and perceptive, and people say I understand their feelings when others don't." That's very different from a hallucination.

DIFFICULT SITUATIONS

Most of the time you will find clients will want to talk about their situation. They will be as anxious as you for a care plan. There are, however, times when the situation is extreme and the client could be overcome with grief or anger. Do not shy away from these situations. You will probably feel more uncomfortable than the client. As a trained professional, you should be able to handle a social interaction which requires attention. Personally, anger is easier for me to handle than grief and extreme sadness. I find the sad situations take a lot more out of me than dealing with anger. If the client becomes overcome with sorrow or begins to cry, handle the situation no matter how difficult it is for you. By following a few guidelines you will find that these situations are not as difficult as you might imagine them to be.

First: Don't ignore the client. Don't pretend they are not crying. Simply be direct, polite and sensitive. Put down your pencil and acknowledge the situation. Use Comments like: "I'm sure that is very difficult for you", or "I'm so sorry." Try reassuring them it is safe to express their grief, loneliness, pain or sadness with you. Even a comment like, "It's O.K. to cry; we all cry," or, "I understand," is effective. Try to remember a time when your eyes swelled up and you could not hold back the tears. Those moments often are most embarrassing. Try to make the client feel comfortable and at ease with their embarrassment.

Second: Don't pity the client. Grief, pain, loneliness and sadness are a part of all of us. The client does not need or want pity. Be respectful, sensitive and handle the situation. If possible personalize it: "My grandmother felt the same way," "That was very difficult for my grandfather too," or, "I understand your fear; my grandmother was very frightened of a nursing home." Don't make up stories, but if you have some understanding of the situation, this would be the time to express it to the client. React to this situation the way you would want someone to react if it was your grandparents or parents. You do not have to indulge the situation, but a brief moment of compassion and understanding is expected.

Third: If at all possible continue on with the assessment. The situation would have to be extreme not to be able to continue. I strongly urge you not to abandon the client or the comprehensive assessment. It leaves the client with a feeling of failure of unfinished business. Comments like, "I hope I didn't upset you?" will help. If you handled the situation correctly, most clients will respond by saying, "No you've been very kind," and you might say, "May we continue with the conversation?" Most clients will be happy to go on and appreciate your kindness and patience. Remember that even though the client may seem sad while talking to you, it still can be a comfort to express feelings. Often the assessor is the one who feels uncomfortable and tries to rush or terminate the interview. Be tolerant of pauses while the client is upset. A good neutral remark is "I know this is difficult and we do appreciate your help."

When dealing with the angry client, it is best to handle the anger before you attempt the interview. If the anger isn't dealt with, it will continue throughout the interview and you will be in constant battle. Handling the angry client in the beginning gives you control and sets the pace of the interview. Handle anger or the angry client with the following techniques:

- Gently confront the client, "You seem to be very upset and I am not sure why. If I have done something to upset you please tell me." If you haven't done anything to upset the client (which is most likely) then say, "I think it is best if we talk about why you are upset before we continue." The client may not be feeling well, or may have a very good reason for being upset. Whatever the situation may be you must get the anger out in the open for you to control the conversation.
- If you are just dealing with an angry person and can not get them to open up, explain what you are doing and that your only purpose is to gather information to help design a care plan. You wish them no harm and would appreciate their cooperation. If said in a calm and pleasant manner most people will cooperate.

COMMON PROBLEMS

GETTING THE CLIENT TO TAKE THE MENTAL STATUS QUESTIONS SERIOUSLY: Although this group of questions are, for the most part, easy to ask and record, they may be inherently difficult because some people will think you are testing their mental capabilities. Again, treat these questions with respect and a straightforward attitude and do not make the client think that answering them is a pass/fail type of situation. If they have trouble with this and it bothers them, try to reassure them that they're doing fine and you're almost done. This is a common problem that will occur over and over. If you are going to take the comprehensive assessment seriously you will have to learn how to handle these situations. People will reject the mental status questions for these reasons:

- They do not know the answers and are behaving defensively.
- They know the answers and feel foolish.
- They are unsure why you are asking them these questions. Is there supposed to be a problem, or do you think that there is something wrong with them?

Handle these situations with care and respect. Reassure the client by saying, "You are being very helpful, I certainly do not want to make you feel uncomfortable. These are questions that are commonly asked of people in your situation. I talk to a lot of different people in many situations. Some questions may seem too easy and some may seem too difficult. I will write down whatever you say. We are almost done and can move quickly through this section if you like." Or else say, "I'm so sorry you feel like I am testing you. I really am not. This portion of our discussion is asked to everyone I talk to. I ask the same questions in the same order to everyone. There is no pass/fail, I write down what you say. Surely you must understand that I talk to a lot of different people in different situations.

This portion of the assessment was designed to reach a large population of people in similiar situations as yours. Some questions may seem too easy, but some questions may seem too hard. Regardless of your situation, these questions are important and I would appreciate your help. I will go quickly through this section."

Do not let the client believe you think these questions are silly, ridiculous, not necessary, or a formality that you are forced to use. All questions must be taken seriously to be effective. It is very important that the assessor never lose respect for the comprehensive assessment, and you should never allow the client to lose respect for it. If you establish the ground rules the client will follow.

The assessment is important and so are <u>all</u> the questions. The same respect should be given these questions and you should handle them the same way you would handle questions that are embarrassing to you.

<u>THE TALKATIVE CLIENT:</u> Every question you ask gives talkative clients an opportunity to tell you a story about their life, their children or events in the world. When you are spending time to develop rapport you will obviously spot the talkative client. Knowing that, the best strategy is to set ground rules. Tell the client what you are going to do, how long it will take and what you need from her. "I have about an hour and a half for this discussion. I will ask you some general questions about your daily life and some more specific questions. It would be very helpful for the consistency of this discussion to stick to this form and ask the questions in the order they appear. I will also be the person working with you when services begin." Or, if more accurate, "my job is to work with you at the beginning to identify your problems and concerns, but another worker will work with you later." This will help establish ground rules, influence the client in letting him/her know what to expect in a future relationship with the case manager, and decide how much bonding is desirable.

Then within these constraints, the worker can say, "This is interesting, I'd like to hear more detail about your reactions to home care the next time I see you because it is so important. Right now, because of our time today, I would like to continue with the assessment interview," or, "Today we need to finish this form, but when services begin another worker will work with you and that would be important information to tell her." If you do have time and, most importantly, if the information would be helpful, you should encourage further information especially when relevant to the care plan. You can say, "I've made a note of that; you like your shower in the evening," or "It's helpful to know you like to play bridge, I've made a note about that." Of course, you should never say you made a note of something unless you actually made a note of it. And you should not say it will make a difference, if nobody will ever look at it again. I have been told that a good case manager makes these notes and <u>uses</u> them often.

<u>THE CLIENT WHO WANTS TO INTERVIEW YOU:</u> Some clients will be as interested in you or your job as you are in completing the assessment. Try to handle personal questions with a sense of humor. If the question is innocent enough answer it. If the personal questions persist or interfere with the process of the assessment gently tell the client, "I appreciate your interest. However, the importance of the assessment is to better understand <u>your</u> opinions on home care and how you feel. This is your opportunity to tell me." If clients want to know if you have children, tell them. If clients want to know your opinion on health care, <u>do not</u> tell them. Remember not to bias the assessment by leading or giving your opinions. Tell the client, "It is important to determine what your needs and opinions are. We are instructed not to express our opinions because it is very important that we do not influence you. That would be unfair to you and the people we talk to."

WHEN I KNOW THE CLIENT IS EMBARRASSED I JUST CAN'T ASK.

QUESTIONS ABOUT INCONTINENCE: If the client is embarrassed, it is your responsibility to reassure the client you are not embarrassed. The purpose is to provide for the needs of the client. Do not guess at what the needs are; ask the question. In my experience it is usually the interviewer who is more embarrassed than the client. If you are the one who is embarrassed, you will have to find a way to overcome your embarrassment. If the comprehensive assessment is to be taken seriously all questions must be asked. Ask these questions straightforwardly and without hesitation. If the client is embarrassed reassure them of the importance of asking all the questions. Try saying, "I certainly did not want to make you feel uncomfortable. I talk to a lot of people with many different needs. The importance of these questions is better understanding you and your needs to provide a care plan that is right for you." If said without embarrasment or hesitation on your part the client will feel reassured.

COMMENTS FROM CLIENTS

Some clients, no matter how much time you spend with them developing rapport, will also need reassurance. They are by nature suspicious people and will not trust you. Do not shy away from them; they just need a little more time and a little more reassurance. If you answer their questions they will eventually cooperate. They may just be toying with you to see how many questions you will answer. Do not let them have control, but do answer their questions and move quickly to the assessment tool. I have tried to think of some common questions and examples of responses to those questions. Sometimes there is no right answer. Just say something to let the client know it is fine for them to question you about what you are doing, and you will be happy to answer any of their questions. For some people it will be answering one question and for the next person you may have to answer five questions. There is no magic number--each individual is different. A good rule is to answer as many questions as needed to complete the comprehensive assessment.

"THESE QUESTIONS ARE STUPID"

I am sorry you feel that way. As I explained earlier, this tool was designed to determine the needs of people in similiar situations as yourself. Not all the questions will apply to you, as I talk to a variety of people and everyone is not the same. I just don't want to answer for you and not give you the opportunity to express yourself. If we come to a question that does not apply, just tell me and we can skip that question, but it is important to get this information from you.

"HOW DO I KNOW YOU WON'T USE THE INFORMATION AGAINST ME?"

There is no way I could use any information against you. My only purpose is to better understand what your needs are and if you qualify for certain programs. I have the opportunity to get to know you and what you may want or may not want in designing a care plan for you. You have the opportunity to have input into your needs. The conversation will go quickly, and you may even find it enjoyable.

"YOU ARE GOING TO DO WHAT YOU WANT ANYWAY WHY BOTHER"

Actually that is not true. This tool was designed with you in mind. The purpose is to ask you and not assume we know what you want or need. There are of course programs that you may not qualify for, but we would like to determine what your needs are and what you want. If we were going to make decisions without you I would not be here. I would like the opportunity to spend some time with you and sort through this. I think it will be very good for you. Why don't we get started and if you have any questions please feel free to stop me.

"THAT'S A PERSONAL QUESTION"

Yes, many of the questions I ask will be personal. As I explained the purpose of this discussion is to better understand your needs and provide a care plan just for you. I appreciate you helping me out and answering these questions. I talk to a lot of people and everyone is an individual.

"MY INCOME IS NONE OF YOUR BUSINESS"

Well, income is a very important question and part of this assessment. Many programs are based on income. In deciding a care plan and your needs, I must determine if such a plan is affordable or if you are eligible for this. If you feel uncomfortable telling me, maybe you would like to write it down for me?

"JUST WHAT ARE YOU REALLLY GOING TO USE ALL THIS INFORMATION FOR?"

The information will be used to provide a care plan that fits your individual needs. This assessment will help us determine your eligibility for certain programs. I can't tell you what you need unless I first sit down and talk to you. An assessment is the fairest way to determine your needs. You have as much say in this as I do.

"JUST WHO GETS TO SEE THIS?"

I will be looking it over, and with your permission the nurse in the program will look at it and a summary of information goes to the main office at the state level of the program. We are very strict with this information and value your openess to talk to me. I keep all the forms in a locked filing cabinet.

ROLE PLAY SITUATIONS

Questions are from the GERIATARIC ASSESSMENT TESTING AND EVALUATION SYSTEM (GATES), from Florida

INTERVIEWER: I'm going to start with some general questions. Some of these questions may seem too easy and some may seem too difficult. Don't worry, just answer the questions the best you can. We will start with: what is today's date?
CLIENT: August 17th, 1990.
INTERVIEWER: What day of the week is it?
CLIENT: Well, it's Monday isn't it?
INTERVIEWER: What do you want me to write down?
CLIENT: Monday.
INTERVIEWER: What is the name of this place?
CLIENT: This is my house. This is getting ridiculous.
INTERVIEWER: We have a few more questions left in this section. What is your telephone number?
CLIENT: 884-2894
INTERVIEWER: How old are you?
CLIENT: How old are you?
INTERVIEWER: I asked you first.
CLIENT: 67 and you?
INTERVIEWER: 39. When were you born?
CLIENT: You mean my birthdate?
INTERVIEWER: Yes.
CLIENT: May 22nd,1923
INTERVIEWER: Who is the President of the United States now?
CLIENT: Are you trying to see if I am crazy?
INTERVIEWER: Absolutely not, I am sorry you feel this way. These questions are part of our standardized assessment that is asked of everyone. I ask the same questions in the same order to

everyone. We are almost done.
CLIENT: Well, it is Bush isn't it?
INTERVIEWER: What would you like me to write down?
CLIENT: I would like you to tell me ... is Bush.
INTERVIEWER: It would be inappropriate for me to answer for you. My job is to write down whatever you say. This section can be difficult, but it is an important part of the assessment. You are doing fine, we only have three questions left in this section and then we can move on to another section. Now what do you want me to write down for: who is the President of the United States right now?
CLIENT :I am sure it is Bush.
INTERVIEWER: Who was the President before him?
CLIENT: Before who?
INTERVIEWER: Before the current President.
CLIENT: I almost got you to tell me didn't I?
INTERVIEWER: You are definitely keeping me on my toes.
CLIENT: Wasn't that Carter?
INTERVIEWER: What would you like me to write down?
CLIENT: It is so frustrating when you can't remember.
INTERVIEWER: You can take a moment and think about it. I don't want you to feel rushed.
CLIENT: I just don't know.
INTERVIEWER: What was your mother's maiden name?
CLIENT: Her name was Susan.
INTERVIEWER: Her last name?
CLIENT: Same as mine.
INTERVIEWER: Last question in this section. Subtract 3 from 20 and keep subtracting 3 from each new number all the way down.
CLIENT: All the way down to what?
INTERVIEWER: Down until you can no longer subtract 3.
CLIENT: Let me get my calculator out of the drawer.
INTERVIEWER: No calculators.
CLIENT: I did not think there would be math questions. This is getting very difficult. I am a smart man, but I never was any good at math.
INTERVIEWER: Would you like to give it a try?
CLIENT: No!
INTERVIEWER: This next set of questions I know you will enjoy. I am going to ask you some questions about how you have been feeling and you can answer "yes" or "no" to each question. This section goes real quickly.

If the interviewer keeps an attitude that is up and positive it will help the client through the difficult questions. I find being honest and straightforward always works best. Don't be afraid to tell the client, "I can't answer for you, but I will write down whatever you want me to write down." Let the client know that you have a job to do and a boss to answer to by saying, "We have been told that it is unfair for me to bias or lead you or answer for you. When we were trained to do these discussions we were told how important it is that we write down only your responses. The purpose of this is to better understand your needs and opinions. All questions may not even apply to you or your situation, but please allow me to ask them and if you would try to answer them I would appreciate it. This can really be an enjoyable conversation".

Questions are from the PREADMISSION SCREENING (PAS) ASSESSMENT FORM from Minnesota;
INTERVIEWER: I'm going to ask you some general questions about how you have been feeling in the past two months. You can answer "yes" or "no" to each of these questions and if you have any questions please feel free to stop me at any time. My first question is: Have you had continued lack of interest in most activities and/or continued low, sad or depresed moods?
CLIENT: Oh yes, I have no interests, I just sit here all day I never see anyone, no one cares, my life is just awful.
INTERVIEWER: Is there anything you are still interested in or activities you still enjoy?
CLIENT: I never miss L.A. Law, I do my jigsaw puzzles every week and my one granddaughter and I visit every Friday morning.
INTERVIEWER: Your visits with your granddaughter sound like they are very enjoyable for you.
CLIENT: Yes, I look forward every Friday to see her.
INTERVIEWER: Have you been sad or depressed in the past two months?
CLIENT: When you are old and sick life isn't good. People forget you or try to make you feel stupid like there is something wrong with you. Like you are doing with some of these questions.
INTERVIEWER: I am so sorry you feel that way. I can honestly say I was not trying to make you feel stupid. I have enjoyed this conversation, I think you are a bright and interesting person. My only objective is to design a care plan that will fit your individual needs. I have never passed any kind of judgement or opinion about you. The questions I ask, I ask to everyone in the same order. The only purpose of this assessment is to better understand you and your needs. I feel badly that I have made you feel uncomfortable. Let's try to continue with this and let me know if I make you feel uncomfortable again. Was it the question about sad or depressed moods that bothered you?

Questions are from the CLIENT ASSESSMENT AND PLANNING SYSTEM (CAPS) form from

on:

INTERVIEWER: I would like to talk to you about some of the personal tasks you do during the day. We will talk about shopping, eating, dressing, bathing and toileting. For each topic I will give you several examples and you tell me which one is closest to your situation. If you need me to repeat the options, I, of course, will be happy to. First, let's talk about dressing. What would be closest to your situation : 1) Can dress and undress without assistance or supervision; 2) Can dress and undress, but may need to be reminded or supervised to do so on some days; 3) Needs assistance from another person to do parts of dressing and undressing; 4) Dependent on others to do all dressing and undressing.

NT: I can do everything but reach that snap in the back or zip dresses with back zippers all the way up. So I guess you would say number 3..

Interviewer would mark number 1.

INTERVIEWER: Now I would like to talk about toileting and the situation that would be closest to you.

CLIENT: Just mark down that everything is fine.

INTERVIEWER: I would like the opportunity to read you the options and then you can tell me which one to mark.

CLIENT: Well, this is embarrassing, I don't like to talk about this and I don't think it is necessary.

INTERVIEWER: Please do not be embarrassed; there is nothing to be embarrassed about. I talk to a different people in different ons. Some people have problems in some areas and some people have problems in some other area. All I need to know is: 1) Can you toilet without physical assistance or supervision. May need grab bars/ raised toilet seat or (can manage own closed drainage system); 2) Needs stand-by assistance for safety or encouragement. May need minimal physical assistance with parts of the task, such as clothing, adjustment, washing hands; 3) Needs substantial physical assistance with parts of tasks, such as wiping, cleansing, clothing adjustment. You may need a protective garment; 4) Cannot get to the toilet unassisted or (you need someone else to manage care of catheter); 5) Physically unable to be toileted. Now, Mr. Jones which of those situations is closest to your situation? I think it would be easier to hand the client a card with the options on it. The interviewer would still have to read the options, but the client can read along. Having cards makes it easier for clients who get embarrassed and for clients with short-term memory loss.

WHAT CAN BE DONE TO HELP YOU DO YOUR JOB?

In research, we have developed the rules and boundaries for each questionnaire we use. Assessing the tool as questions arise, and the program may develop rules and standards as it goes along. When you have questions about what a question means, how to probe a question or how to determine an answer, ask! If there isn't an established answer there should be. You can help set standards that will help you and other social workers and nurses do their job better and easier. Would cards with explanations on them for dressing and toileting help? If the wording is incorrect, let's change it. The comprehensive assessment should be read the way it is written, if it is written correctly. If it is not being understood and reliable information is not being gathered, then let's change the wording. Your help and feedback is necessary. You are the one in the field asking the questions; only you can tell us what is being understood, where the problems are, and how we can help you with your job.

Choosing the Right Questions

Direct or Closed-ended questions –

- Are questions that seek a simple "yes' or "no' answer.
- Specifically ask for information. For Example: "Are you coming tomorrow?" or "Do you eat three times a day?"
- These questions do not encourage or allow for an explanation of why the answer was chosen, or for an elaboration of thought or feeling about the answer.
- They can be leading –they ask a question in narrow terms such that they seem to be "hinting" at the answer.

Open ended questions –

- Cannot be answered by yes or no.
- These questions begin with 'who', 'what', 'where', and 'when' or 'how.'
- They give consumer's more choice in how they answer and will encourage them to describe the issue in their own words.
- Open-ended questions seek out the consumer's thoughts, feelings, ideas and explanations for answers.
- They encourage elaboration and specifics about a situation. For example: "How are you able to bath yourself?"

Indirect Questions –

- Ask questions without seeming to.
- They are not stated as a question.
- In these the interviewer is asking a question without stating it in question format. For example: "you seem like you are in a great deal of stress today."

Open Ended Question for Interviews

Opened ended questions cannot be answered by yes or no. These questions usually begin with "who", "what", "why", "where", and "when."

1. Tell me in your own words what you need in the way of help?
2. What do you need in the way of help right now?
3. Let's talk about things you are able and not able to do.
4. Help me understand….
5. What do you mean by_____?
6. Would you tell me more about…?
7. What else can you tell me that might help me understand?
8. Could you tell me more about what you're thinking?
9. I'd be interested in knowing…
10. Would you explain…?
11. Is there something specific about _____that you are asking for?
12. Would you explain that to me in more detail?
13. I'm not certain I understand…Can you give me an example?
14. I'm not familiar with_____, can you help me to understand?
15. What examples can you give me?
16. Can you tell me what you already know about_____?
17. What (else) would you like to know about _____?
18. When you say _____, what do you mean?
19. I'd like to help you get the best possible service, what more can you tell me that will help me understand your need?

Adapted from: *Understanding Generalist Practice*, Kirst-Ashman and Hull Nelson-Hall Publishers

Other Assessment Cues

Non-verbal Assessment Cues:

Your Body Speaks Your Mind

- Between 60-80% of our message is communicated through our Body Language, only 7-10% is attributable to the actual words of a conversation.
- Whenever there is a conflict between verbal and non-verbal, we almost always believe the non-verbal messages without necessarily knowing why.

Eye contact – it is important to look a consumer directly in the eye. Hold your head straight and face the consumer. This establishes rapport and conveys that you are listening to the consumer. This is not staring, but being attentive.

Facial expressions – these are the strongest nonverbal cues in face-to-face communication. Be aware of your own non-verbal –what are my habits that could be interpreted wrongly. Make certain that your facial expressions are congruent with your other nonverbal behavior. (crossing arms, hands on hips, other…not portraying your interest) What do I see in the other person's face? If unclear ask for interpretation.

Body positioning – posture, open arms versus crossed. When interviewing consumers look for cues in their body positioning, and be aware of your own. Sitting in an attentive manner communicates you are interested.

Environmental Cues

- Discrepancies between the way the environment looks and what consumer reports as service needs.
- Importance of observations, *(house condition, cleanliness of consumer, tour house)*.

Sensory cues

- Data obtained by smelling.
- Tactile information –sticky floors, surfaces.

Assessment Skills

Establishing Rapport –

Warmth, Empathy and Genuineness

- **Warmth** –conveys a feeling of interest, concern, well-being and affection to another individual. It promotes a sense of comfort and well-being in the other person. Examples: "Hello. It's good to meet you."; "I'm glad we have the chance to talk about this."; "It's pleasant talking with you."
- **Empathy** –Being in tune with how a consumer feels, as well as conveying to that consumer that you understand how she/he feels. Does not mean you agree. Helps consumer trust that you are on their side and understand how they feel. It also is a good way to check to see if you are interpreting what you observe correctly. Mirroring non-verbal can send empathetic messages. Example of leading phrases: "My impression is that…"; It appears to me that…"; "Is what you're saying that…"; You seem to be…."; "I'm hearing you say that…"
- **Genuineness** –means that you continue to be yourself, despite the fact that you are working to accomplish goals in your professional role. Being yourself and not pretending to be something you are not. This conveys a sense of honesty and makes them feel that you are someone they can trust.

General Interviewing Skills

Before the Interview –review the case and think about the possible things you will need to assess with this consumer. Are there any cues from the initial information that help you to come up with an approach to the interview? For example: is the patient ESL, blind, mentally impaired?

Pre Interview Planning - Be Prepared

- Review case file and gather cues about consumer
- Formulate questions based on cues
- Plan interview approach

Meeting the Consumer - Establish Rapport

- Introductions should be formal and cordial
- Small talk to get the conversation going
- Pay attention to verbal and non-verbal cues

Begin Assessment Interview - Explain Process

- Explain purpose of interview
- Explain your role to the consumer
- Ask the consumer for feedback – do they understand the process and purpose?

Concluding the Interview –

- Clarify - Next steps
- Explain – Additional paperwork needed before authorization of services
- Discuss – Notification process of authorized hours
- Answer - Questions the consumer may have

Communication Tools

Communicating in Difficult Situations

1. Listen for full understanding of the person's perspective. Allow them the opportunity to give you a clear picture of what they are trying to say.

2. Put the person at ease using non-verbal cues that show interest and concern.

3. Take the time you need to really understand the situation. In the long run spending a few more minutes now will save time in avoiding conflict.

4. Respond to concerns the consumer may have in an affirming manner. Restate their concerns in a way that shows you have heard their issues.

5. Focus on the overall goal of the situation. Avoid personalization of the issues. Keep the conversation professional.

6. Understand what you do Today will have an Effect on Tomorrow. The more effective you are in dealing with the issue at hand, the less the issue will grow and consume your energies.

Handling Hostility

The following are suggestions for handling consumer hostility:

1. Don't get angry or defensive. Recognize your own reactions. Remember that this is a professional not personal issue.

2. Don't patronize or lecture. Saying things such as, "why don't you just calm down" will only escalate the problem and is disrespectful to the consumer.

3. Allow the consumer to voice his/her concerns. Respond with acceptance and understanding. Be empathetic. Listen to understand the situation from the consumer's perspective.

4. Be positive –don't attack them. Show them respect for their discomfort.

5. Greet anger with calmness –set the mood for calm discussion and resolution.

6. Understand the facts regarding the situation that is upsetting the consumer. If you don't have the facts, state what you will need to find out and when you will get back to them.

7. Focus on present and future. Avoid allowing the consumer to get stuck in the past. Emphasize what can be done positively in the future, not what has happened in the past.

8. Ask questions – "How can I help?" Often the consumer knows what they want from you. If you understand their wants you will be able to discuss future possibilities with that in mind.

9. Summarize for clarification and understanding.

10. Be honest about your next steps. If you can't fix the problem outright don't make promises that you cannot keep. If there are consequences to the behavior let the consumer know.

Adapted from: *Understanding Generalist Practice*, Kirst-Ashman and Hull Nelson-Hall Publishers and *Connecting with self and others*, Sherod Miller et.al. Interpersonal Communications Programs, Inc.

Things to consider when dealing with someone who is hostile:

1. Try to evaluate as honestly as you can by reasoning with yourself whether his/her anger is justified.

2. Put hostile people in perspective. You are probably nothing but an afterthought to them, so don't take their antics personally. They're not concerned about you because they're too busy worrying about themselves.

3. Take your pick – positive or negative. You cannot concentrate on constructive, creative alternatives or solutions while you cling to negative feelings. Vent your emotions to a fellow worker or your supervisor and cool off. Think about the result you really want, the consequences or outcome that will benefit the consumer the most.

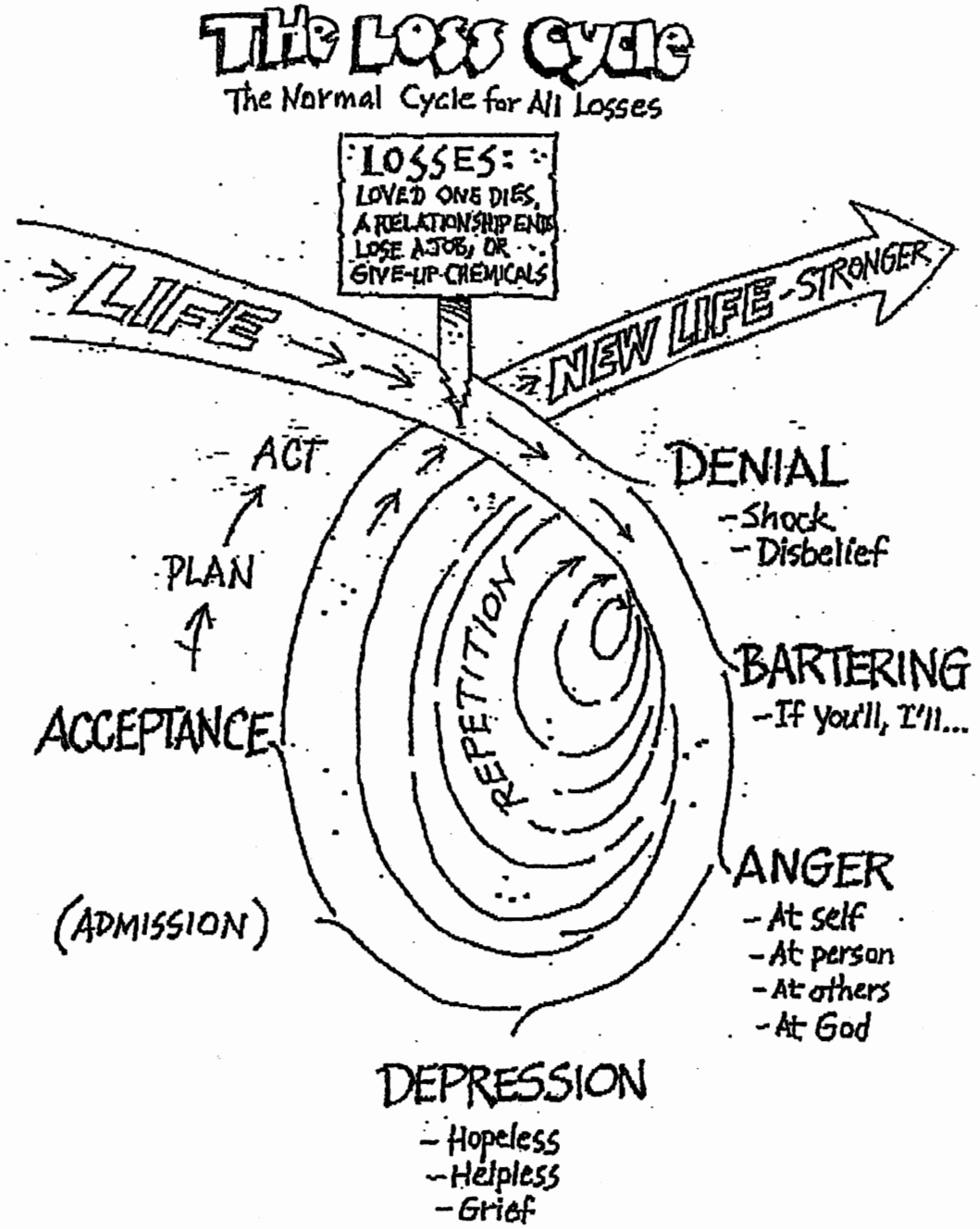
4. Don't expect hostile people to change. They will not. And in a way that is good. Because their behavior is predictable. They may not change but by choosing a better approach you can change the outcome.

5. Learn to respond as well as listen. Ask questions instead of making accusations. If you let others save face, you give them room to change their minds.

6. Request feedback. Use open ended questions to let emotional people vent their feelings before you try to reason with them and explore options.

7. Be straightforward and unemotional. The more you remain calm and matter-of-fact, the sooner you gain another's confidence. People want to feel you are leveling with them, that they can trust you. Remember that respect from other begins with self-respect.

8. Be gracious. Someone else's rudeness does not give us the right to be rude. Treat the other with the kindness you would like to be shown and allow them to feel important. When our own egos are healthy, we are rich; we can afford to be generous.


The Loss Cycle
The Normal Cycle for All Losses
LOSSES:
LOVED ONE DIES,
A RELATIONSHIP ENDS
LOSE A JOB, OR
GIVE-UP-CHEMICALS
LIFE
NEW LIFE-STRONGER
DENIAL
-Shock
-Disbelief
BARTERING
-If you'll, I'll...
ANGER
-At self
-At person
-At others
-At God
DEPRESSION
-Hopeless
-Helpless
-Grief
(ADMISSION)
ACCEPTANCE
PLAN
ACT
REPETITION

Some Facts about GRIEF

Two simple *Definitions* of grief are:

1. the conflicting feelings caused by the end of or change in a familiar pattern or behavior.
2. a normal, natural and painful emotional reaction to loss.

Causes of Grief:

- passing of a human life, as well as for the
- death of a relationship (divorce),
- loss of health and function and loss of independence.
- Loss of a pet.

Grieving involves intense feelings - love, sadness, fear, anger, relief, compassion, hate, or happiness to name a few. These feelings are intense, disorganizing and can be long lasting. Grieving has been described as drowning in a sea of painful emotions.

Stages of Grief.

1. Shock – Immediately following the death of a loved one it is difficult to accept the loss. A feeling of unreality, a feeling of being-out-of-touch.
2. Emotional Release –Awareness of enormity of loss is realized accompanied by intense pangs of grief. In this stage a grieving individual sleeps badly and weeps uncontrollably.
3. Panic – Feelings of mental instability, wandering around aimlessly, forgetting things, physical symptoms.
4. Guilt – Feelings of guilt about failures in relationship, ability to change situation, to save deceased.
5. Hostility / Anger – Feelings of anger over the situation, cause of death and sometimes even at the deceased.
6. Inability to Get back to Normal – Difficulty in regaining normality of daily living. Difficulty in concentrating on the day – to –day activities. The grieving person's entire being, emotional, physical and spiritual, is focused on the loss that just occurred.
7. Acceptance of Loss – Life balance slowly returns. There are no set timeframes for healing. Each individual is different.
8. Hope – The pains of grief are still present but the grieving person is able to find hope for the future. The individual is able to move forward in life with good feelings knowing they will always remember and have memories of the loved one.

Note: Consumers may pass through each stage more than once, and may be in more than one stage at a time. There is no particular order in which they may work through these stages. Even if they appear to have reached the end, another loss may trigger them to go back in to another stage.

Helping Consumers through the grief process:

- Encourage consumer to take their time going through the grief process. Support them and family not to try to rush the process.
- Explain to the consumer that because this is a time of instability and high emotions, it is not a good time to make major life decisions.
- Encourage use of support groups for drug and alcohol if consumer / family have history of dependency.
- Help consumer to understand that they will have good days and bad days.
- Encourage them to seek out people who can listen to their stories and remember their loved ones.
- Reinforce that grief is a very personal and individual process -no one experiences it the same way.

Complex Assessment Situations (Disabilities)

GENERAL ETIQUETTE
For
Interacting with People with Disabilities

If you are interacting with people with disabilities for the first time: BE YOURSELF !
As in any new situation, everyone will feel more comfortable if you relax.

Tips on Conversation:

1. Talk with the person with a disability, not their spouse, assistant, interpreter, or others nearby. Maintain the eye contact and body language you would normally use during any other conversation.

2. An important thing to remember in any conversation with someone who has a disability is: "assume nothing." If you have a question about what to do, what language or terminology to use, or what assistance — if any — they might need, the person with the disability should be your first and best resource. Do not be afraid to ask their advice.

3. Be patient — not only with the person with the disability, but with yourself. Frustration may come from both sides of the conversation, and needs to be understood and dealt with by both parties.

4. The most important thing to focus on during a conversation with a person who has a disability is the overall goal. It is simply communication between two individuals. Ultimately, it is what is communicated — not how it is communicated — that will be important.

SPECIFIC DISABILITIES

The following summary of the characteristics of different types of disabilities contains many true statements, but no absolute truths: *Remember that every person with a disability is an individual.*

While this summary is about disabilities, it is important to remember that you are not interacting with disabilities; you are interacting with *individuals* with disabilities. Remember also that they are people first.

It is most important to ask the individual what terminology they prefer, or if they need assistance. With this in mind, the following general guidelines are offered.

BLIND OR VISUALLY IMPAIRED

Things to Know:

1. Most persons who are blind have some sight, rather than no sight at all.

2. Many people who are blind are mobile and independent. Some people who are blind view blindness not as a disability as much as an inconvenience.

3. While many people who are blind can use Braille, the majority of persons who are blind do not.

Things to Do:

1. Introduce yourself. Identify who you are and what your job or role is. Give the person verbal information that is visually obvious to those who can see. If you have met before, remind them of the context; they won't have the visual cues to jog their memory.

2. Be descriptive when giving directions. Saying "over there" has little meaning to someone who cannot see you point. "Four doors after turning right from the elevator" would be much more helpful.

3. Always ask someone if they need your assistance and how you can assist them. Lead someone who is blind only after they have accepted your offer to do so. Allow them to hold your arm, rather than you holding them. It is important to let people with vision impairments control their own movements.

4. Many techniques are used as tools for independence, but individuals with disabilities use only things that work for them. Remember to describe sights or objects from their perspective, not yours. Tell them when you have brought new items into their environment, describing what they are and, most importantly, where you have put them.

Things to Avoid:

1. Do not move items (furniture, personal items) after their position has been learned by the person. This can be frustrating and, in some cases, dangerous for the person with a disability.

2. Do not use references that are visually oriented like, “over there near the green plant.”

3. Do not interact with a service dog while it is working (in harness).

Things to Consider:

1. Persons who are blind have more often been told what to do rather than asked what they would prefer doing. This attitude is not acceptable towards any person.

DEAF AND/OR HEARING IMPAIRED

Things to Know:

1. Most persons who are deaf or hearing impaired have some hearing, rather than no hearing at all.

2. Sign language is not another form of English; it is an official language with its own grammar, contexts and rules. Not all persons who are deaf use sign language.

3. Lip-reading, while helpful without sound clues, is only 30% - 50% effective, and sometimes less. Not all persons who are deaf lip-read.

4. Long conversations with persons who can lip-read can be very fatiguing to the person who has the disability.

5. Not all persons who are deaf write and read.

6. Not all persons who are deaf speak.

Things to Do:

1. Find out how the person communicates best.

2. If the person uses an interpreter, address the person, not the interpreter.

3. If the person reads lips, speak in a normal, not exaggerated, way. Short simple sentences are best.

4. If the person lip-reads, avoid blocking their view of your face. Make sure the lighting is good.

5. Gain the person’s attention before starting a conversation.

6. If there is some doubt in your mind whether you were understood, rephrase your statement and assure that understanding has been reached.

7. Be aware of situations where a person may be waiting for a service (transportation, a table, the start of an activity) where the common way to communicate is an announcement or the calling of the person's name. Advise them when their name is called. Make sure you take notes when someone cannot hear you, and develop an alternative method of notifying them.

Things to Avoid:

1. Do not become impatient or exasperated with the person if it takes longer to communicate.

2. Make sure there are no physical barriers between you and the person you are in conversation with.

3. If the person is using hearing aids, avoid conversations in large, open and noisy surroundings.

Things to Consider:

1. Persons who may deal very well one-on-one in communication may have a hard time with two or more speakers, especially if there are many interruptions and interjections.

2. Showing impatience to someone who is deaf or hearing impaired may cause the less assertive person to back off from telling you of his or her needs.

3. When someone asks, "What did you say?" the answers, "Never mind," "Nothing," or "It's not important," are very common replies. These are insulting and demeaning because they communicate that the person is not worth repeating yourself for.

PEOPLE WHO USE WHEELCHAIRS OR OTHER MOBILITY DEVICES

Things to Know:

1. There are many reasons (not just being paralyzed) which might require someone to use a wheelchair. These might include loss of stamina or equilibrium, or a temporary condition like a fracture or recovery from surgery.

2. There are a wide range of physical capabilities among people who use wheelchairs. This means that persons who use them may require different degrees of assistance, or no assistance at all.

3. Some persons do not use wheelchairs exclusively, but may also use canes, leg braces and, in some cases, no assistive devices at all—or only for short periods.

4. All wheelchairs are not the same. Different sizes and shapes meet different needs. Some wheelchairs move manually and others are motorized. Just because one person can access an area in his or her wheelchair does not mean that everyone with a wheelchair may be able to do so.

Things to Do:

1. If you are asked to fold, carry or store a wheelchair, treat it with the same respect that you would if you were holding someone's eyeglasses. They are similar in many ways. Wheelchairs can break, they are difficult to have repaired on short notice and on weekends, and it is extremely disruptive to the user when they are out of commission.

2. When you meet someone seated in a wheelchair, extend your hand to shake if that is what you normally do. A person who cannot shake hands will let you know. They will appreciate being treated in a normal way.

3. When speaking to someone who uses a wheelchair, remember to give the person a comfortable viewing angle of yourself. Having to look straight up is not a comfortable viewing angle.

Things to Avoid:

1. Do not approach someone who is using a wheelchair and start pushing him or her without asking.

2. When communicating, do not stand too close to the person in a wheelchair. Give him or her some space.

Things to Consider:

1. It is a very common experience for persons who use wheelchairs to be told that some place is accessible when it is not. Listen carefully when anyone who uses a wheelchair tells you that some area which you thought was accessible is not.

2. Do not assume that the person using a wheelchair needs assistance. Ask the person if there is anything special you can provide.

CONDITIONS WHICH CAUSE DIFFICULTY WITH SPEECH

Things to Know:

1. There are many reasons for having difficulty with speech. Deafness, cerebral palsy, stroke, head injury, physical malformation of speech mechanisms, and general speech impairment are just a few.

2. It is not unusual in stressful situations for someone's speech to become harder to understand.

Things to Do:

1. If you do not understand what a person is saying, bring it to his or her attention immediately and ask how the two of you may communicate more effectively.

2. If it is a stressful situation, try to stay calm. If you are in a public area with many distractions, consider moving to a quiet or private location.

3. Consider writing as an alternative means of communication.

4. If there is no solution to the communication problem that can be worked out between you and the person, consider asking if there is a person who could translate or interpret what he or she is saying.

Things to Avoid:

1. Do not pretend to understand when you really do not.

2. Do not become exasperated or impatient with the communication process.

3. Do not finish sentences for the person with a disability.

Things to Consider:

1. Many persons with difficulty speaking find themselves in situations where people treat them as if they are drunk, developmentally disabled or mentally ill. They are accustomed to being avoided, ignored, or even hung up on by phone.

2. Accessibility for persons with difficulty in speech lies within your power. Your patience and communication skills are as important to someone with speech that is difficult to understand as a grab bar or a ramp is to someone who uses a wheelchair.

DEVELOPMENTAL DISABILITIES

Things to Know:

1. Developmental Disability refers to conditions occurring before adulthood which sometimes result in below average intelligence, impaired motor functioning, cerebral palsy, autism or other disabling conditions.

2. A low intelligence test score alone does not necessarily indicate that a person is developmentally disabled.

3. What is seen by most people is behavior reflecting slow, arrested, or incomplete development before a person reaches the age of eighteen.

4. It is important to remember that, even though someone is an adult, there are certain characteristics which are described as childish or childlike, leading to the erroneous conclusion that a person has a "mental age of 4 or 5". A person who is 30 years old with a mental age of five has had 25 more years of life experience upon which to base his or her behavior.

5. Because each person with a developmental disability is an individual, there is no "overall" description one can give to alert that a person is developmentally disabled. Every person with a developmental disability will display characteristics differently, with varying levels of intensity.

6. Not all people with developmental disabilities look disabled, nor will they act in the same way when making contact with people.

Things to Do:

1. A calm, patient attitude on your part will prove to be your most effective tool.

2. Be aware that a "yes" response may be inappropriately given out of fear of disapproval or in an attempt to please.

3. If a person with a developmental disability is lost, be aware that residents of Board and Care homes may have their names printed on their clothes, collar or similar location.

Things to Avoid:

1. People with developmental disabilities may not have any speech, or may have very limited speech. Avoid frightening a person with developmental disabilities, as they may be unable to respond because of fear. They may, however, respond to questions, especially those requiring a "yes" or "no" answer.

Things to Consider:

1. Medication may slow their speech or reactions, or cause them to walk in a manner which arouses suspicion.

CEREBRAL PALSY

Things to Know:

1. Cerebral palsy is a condition that results from damage to the central nervous system before birth, or early in life.

2. "Cerebral" refers to the brain and "Palsy" to a disorder of movement or posture.

3. It is neither progressive nor communicable, and has little or no relation to intelligence.

4. Cerebral Palsy is characterized by an inability to fully control motor functions. A person with Cerebral Palsy may have spasms; involuntary movement; disturbance of gait or mobility; seizures; abnormal sensation and perception; impairment of sight, hearing, or speech; and mental retardation.

Things to Do:

1. To the uneducated observer, a person with Cerebral Palsy may be thought to be ill or drugged. Your experience with others who are under the influence of a variety of drugs could help you to determine the difference.

Things to Avoid:

1. Do not make assumptions about the intelligence of persons with Cerebral Palsy.

Things to Consider:

1. Over a half million people in the United States have Cerebral Palsy. Many are wheelchair users and you may refer to the previous section concerning wheelchairs for additional information.

EPILEPSY

Things to Know:

1. Epilepsy is a symptom of a disorder of the central nervous system occurring either as a result of head trauma or as a condition present from birth, which may result in seizures.

2. Epilepsy is not a disease, nor is it progressive, related to intelligence, or necessarily related to another disability.

3. One person in a hundred has epilepsy; however, 80% of those diagnosed will have good control of seizures through medication.

4. There are three seizure patterns:

    - The Grand Mal convulsion consists of a loss of consciousness, stiffening, muscle rigidity and spasms.

    - The Petit Mal seizure may not be readily recognized, as it usually consists of a lapse of from 5 - 25 seconds and gives the appearance of daydreaming or staring.

    - The Psychomotor seizure may be seen only as staring or confusion, dizziness or fear, or other behavior such as lip smacking or erratic arm movements.

Things to Do:

1. At the scene of a seizure, your best action would be to keep the person from getting injured by removing objects from the area which might cause injury (chairs, tables, etc.).

2. If the person is still unconscious after a seizure, turn him or her on their side, with the face downward.

Things to Avoid:

1. Do not restrain the movements of a person having a seizure.

2. Do not put anything between the teeth.

3. Do not give the person anything to drink.

Things to Consider:

1. Medical aid for epilepsy is usually not necessary unless a seizure lasts longer than 15 minutes.

2. The person may not remember what has happened, and may require your assistance for a short period of time while getting reoriented.

3. Seizures usually draw a crowd of onlookers. This is an excellent opportunity to set an example for others by your conduct, and educate the uninformed as to successful intervention techniques.

AUTISM

Things to Know:

1. Autism is a severely incapacitating lifelong developmental disability that appears during the first three years of life.

2. In it's broad definition, autism or autistic-like symptoms occur in about five out of every thousand children.

3. Autism is four times more common in males than in females, and is found throughout the world in families of all racial, ethnic and social backgrounds.

4. Symptoms of autism include:

    - Slow development, or lack of physical, social and learning skills.

    - Immature rhythm of speech and limited understanding or use of words.

    - Abnormal responses to sensations: sight, hearing, touch, pain, balance, smell, taste, etc.

    - Abnormal ways of relating to people, objects and events.

Things to Do:

1. Quite often, when you come into contact with people with autism, they will be in their neighborhood or where family or friends are near.

2. There are no hard and fast rules for dealing with people who have autism.

3. Be aware of the symptoms of autism.

4. A calm, persistent approach should work best.

Things to Avoid:

1. Resist the natural tendency to counter aggression or non-compliance with physical control, since merely touching someone with autism might cause them to flee.

2. Attempting to confine a person who is autistic might cause great fear and resistance.

Things to Consider:

1. Autism is perhaps the most challenging disability with which to cope.

2. At first glance, the actions of persons with autism may seem to be hostile, antagonistic, bizarre or drug-induced.

3. People with autism sometimes feel pain when others would not, and at other times feel no pain.

4. Your attention may be drawn to people who are autistic by their "odd" behavior.

5. People with autism may show a fascination with something inanimate (especially wheels or circular objects), walk into traffic without looking, or be engaged in other aggressive or self-injurious behavior.

PSYCHIATRIC DISABILITIES AND NEUROLOGICAL DISORDERS (ALZHEIMER'S DISEASE, MENTAL ILLNESS, TRAUMATIC BRAIN INJURIES)

Disabilities which do not manifest themselves with physical symptoms can present unexpected complications when interacting with anyone you do not know. What might be considered a "normal" conversation could change without warning or apparent cause.

The onset of the broad group of disabilities which affect the brain can be from a variety of causes: injury, illness, age, drug abuse, trauma or for no apparent reason. In some cases, the person with a disability may exhibit no symptoms most of the time; even medical professionals can have difficulty identifying the full extent of the mental disability, or its causes.

Things to Know:

1. Alzheimer's Disease normally affects people who are older. Childlike characteristics or symptoms may suddenly appear, and memory loss is the most common sign that Alzheimer's Disease is present. People who have Alzheimer's Disease often wander away from their residences, and may have very plausible explanations of where they think they are going.

2. Mental Illness covers a broad range of psychiatric disabilities: schizophrenia, manic depression, severe depression, and most anxiety disorders. Some of these mental illnesses can be treated with medicine but, because they do not recognize that they are ill, people who have mental illness frequently stop taking their medication.

3. Traumatic Brain Injury (TBI), or head injuries, can occur in accidents which sometimes appear minor. A person with a TBI may not recognize that their characteristics or actions change when the injury's symptoms are manifested. Even if there are normally no signs of a TBI present, a sudden change in speech pattern or volume, a burst of anger, or an indecipherable sentence could be an indication that a head injury has occurred.

Things to Do:

1. Mental disabilities can be so varied that there are no easy rules for dealing with the symptoms they cause.

2. Be alert for unusual characteristics, actions or phrases; if they present, assume that there may be some type of disability present.

3. A calm, friendly approach works best while interacting with anyone.

Things to Avoid:

1. Resist the natural tendency to counter aggression or non-compliance with physical control, since merely touching someone with a mental disability might cause them to flee or react violently.

2. Tones of voice, actions, or appearance which are threatening to a person with a mental disability could trigger an unexpected or unwanted reaction.

Things to Consider:

Neurological disorders and the broad range of mental illnesses present challenges for medical professionals, family members, friends, and the people affected by the

disabilities. Your interactions and conversations with people who have such disabilities may be frustrating or unnerving at times. By remaining calm, friendly and helpful you should be able to attain your objective despite the complications which are involved.

HIDDEN DISABILITIES

Not all disabilities are apparent. A person may have trouble following a conversation, may not respond when you call or wave to them, may make a request that seems strange to you, or may say or do something that seems inappropriate. The person may have a hidden disability, such as low vision, a hearing impairment, a learning disability, traumatic brain injury, mental retardation, or mental illness.

Don't make assumptions about the person or their disability. Be open-minded.

LEARNING MORE

Lack of knowledge or misinformation may lead you to shy away from interacting with persons with certain disabilities. Preconceptions about mental illness, AIDS, cerebral palsy, Tourette Syndrome, Alzheimer's Disease and other disabilities often lead to a lack of acceptance by those around the person.

Remember that we are all complex human beings; a disability is just one aspect of a person. Learning more about the disability may alleviate your fears, and can pave the way for you to see the person for who they really are. Keep practicing, and enjoy the experience.

LANGUAGE TIPS

There are some general hints which can help make your communication and interactions with people with all types of disabilities more successful:

1. The preferred terminology is "*disability*" or *disabled*, not "*handicap*" or "*handicapped*." Never use terms such as "*retarded, dumb, psycho, moron"* or *"crippled"*; they are very demeaning and disrespectful to people with disabilities.

2. Remember to put *people first*. It is proper to say "*person with a disability"*, rather than "*disabled person*."

3. If you are unfamiliar with someone, or their disability, it is better to wait until they describe their situation to you than to make your own assumptions about them.

Many types of disabilities have similar characteristics, and your assumptions may be wrong.

Repeated Reminders — Tips on Conversation:

1. Talk with the person with a disability, not their spouse, assistant, interpreter, or others nearby. Maintain the same eye contact, tone of voice and body language you would normally use during any other conversation.

2. An important thing to remember in any conversation with someone who has a disability is: "assume nothing." If you have a question about what to do, what language or terminology to use, or what assistance — if any — they might need, the person with the disability should be your first and best resource. Do not be afraid to ask their advice.

3. Unless you know that you are speaking with someone who has a cognitive or hearing disability, use your normal speaking speed. It is always a good idea to speak clearly, without mumbling or slurring words.

4. Don't be overly friendly, paternalistic, or condescending when speaking to a person with a disability. Most people, even if they are unable to speak to you in a "normal" manner, have normal or above-average intelligence. Your use of abnormal speech or simplistic language will lessen the chances of having a successful conversation.

5. Be patient — not only with the person with the disability, but with yourself. Frustration may come from both sides of the conversation, and needs to be understood and dealt with by both parties.

Once again, the most important thing to focus on during a conversation with a person who has a disability is the overall goal. ***It is simply communication between two individuals.*** Since about 20% of people in our society have some type of disability, you never really know when that will be a factor in one of your conversations.

Working With Blind Consumers in IHSS

Aid codes for blind aid are “20”, “26”, “28”, etc.

- Best corrected vision for statutory blindness 20/200 or visual field <15º

Most common causes of blindness:

- Lack of oxygen and other delivery impairments at birth
- Macular degeneration (degenerative blemishes on the retina), which results in ‘tunnel vision”
- Glaucoma (increased pressure and hardening of the eyeball)
- Diabetes (diabetic retinopathy)
- Cataract (lens becomes opaque)
- Now often corrected or improved by surgery
- Retinal detachment (retina is light-sensitive cells at back of eyeball. If they detach from the optic nerve, visual image cannot reach the brain)

Medications currently used for blindness

- Botopic –drops
- Timopic –drops
- Xalatin –drops
- Diamox –pills
- Laser treatments

Assessment of home care needs of the blind

- Legal blindness covers a wide range of vision. Don’t assume about consumer capabilities
    - Ask Consumer how much vision they do have
    - Ask consumer to identify number of fingers held up by worker
    - Ask consumer to describe worker appearance
    - Ask consumer to describe color of clothing worker is wearing
- Find out how much training consumer has had
    - What kind?
    - How much mobility training?
    - What “gizmos/trick”?
    - Those with intensive schooling are often Braille capable and very adept to getting around.
    - Those who are blind from birth often have mental health issues overlay basic blindness impairment. Isolation due to never having the sight experience
    - Those with late or adult onset tend to have a slower diminution of sight, allowing time to adapt.

- Community resources
    - Department of Vocational rehabilitations; OCB
    - Living Skills Centers
    - Guide dogs

Adapted from original document by; Rita Allen as edited by Ken O’Day 6/11/01

- Special mobility training
- Nonprofit organization serving the blind
- Special services from utilities
- Large print books

- Explore other health problems and their impact on functioning

- IHSS Tasks
  - Domestic: Explore for sign of vermin too small for consumer to see, also crumbs, grease or mold.
  - Meals & cleanup: Same as above. Explore for vermin, encourage microwaving.
  - Laundry: Explore for spots and stains. Consumers often have trouble with use of bleach, pre-spotting, coordination of colors, storing clothing in matching sets to facilitate dressing.
  - Dressing: store clothes in matching styles, colors. Consumers feel seams to determine right-side out. Also feel label to feel back for front. These are some of the skills taught in the training programs.
  - Bowel and bladder: Often creates a mental problem due to shame.
  - Feeding: Consumers rely on things being in place; don't move anything without permission. Plate and table settings need to be in designated spots.
  - Bathing and Grooming: Most men use an electric razor. Observe hairstyle as a factor in grooming time. Provider may need to do set-ups.
  - Accompaniment to MD visits: Can be approved only for consumers who need physical assist
  - Paramedical: Can be involved with administration of insulin injections.
  - Setting up medi-sets can be helpful.

Cultural Resources

Culture Resources

Enhancing Your Cultural Communication Skills

The following questions may assist clinicians in assessing clients and families from culturally diverse backgrounds.

So that I might be aware of and respect your cultural beliefs...

1. Can you tell me what languages are spoken in your home and the languages that you understand and speak?
2. Please describe your usual diet. Also, are there times during the year when you change your diet in celebration of religious and other ethnic holidays?
3. Can you tell me about beliefs and practices including special events such as birth, marriage and death that you feel I should know?
4. Can you tell me about your experiences with health care providers in your native country? How often each year did you see a health care provider before you arrived in the U.S.? Have you noticed any differences between the type of care you received in your native country and the type you receive here? If yes, could you tell me about those differences?
5. Is there anything else you would like to know? Do you have any questions for me? (Encourage two-way communication)
6. Do you use any traditional health remedies to improve your health?
7. Is there someone, in addition to yourself, with whom you want us to discuss your medical condition?
8. Are there certain health care procedures and tests which your culture prohibits?
9. Are there any other cultural considerations I should know about to serve your health needs?

http://www.med.umich.edu/multicultural/ccp/questions.htm#skills

Suggested Content for Enhancing Cultural Competency

1. Interview and assess consumers in the target language or via appropriate use of bilingual/bicultural interpreters.
2. Ask questions to increase your understanding of the consumer's culture as it relates to health and daily living practices.
3. Where appropriate, formulate plans, which take into account cultural beliefs and practices.
4. Write instructions or use handouts if available.
5. Effectively utilize community resources.
6. Request the consumer to repeat back information provided to ascertain understanding of the message (educational and language barriers).
7. Clearly communicate *expectations*. Speak slower, not louder. When appropriate, use drawings and gestures to aid communication.
8. Make no assumptions about education level or professionalism.
9. Avoid using phrases such as "you people" and "culturally deprived", which may be considered culturally insensitive.
10. A reflective approach is useful. Examine your own biases and *expectations* to understand how these influence their interactions and decision-making.
11. Listen carefully.

Adapted from: Patient Education Oversight Committee, UMHS www.med.umich.edu/pteducation/cultcomm2.htm

Complex Assessment Situations (Alzheimer's)

Alzheimer’s Facts

Definition of Alzheimer's Disease

Alzheimer's disease is a group of disorders involving the parts of the brain that control thought, memory, and language. It is marked by progressive deterioration, which affects both the memory and reasoning capabilities of an individual.

Description of Alzheimer's Disease

Alzheimer's disease is the most common form of dementia (mental deterioration of memory and thought processes) among the elderly. It is estimated that 4.5 million Americans over the age of 65 are affected with this condition. After the age of 65, the incidence of the disease doubles every five (5) years and, by age 85, it will affect nearly half of the population.

Alzheimer's disease was first described in 1906 by German neurologist Alois Alzheimer. The disease causes irreversible changes in the nerve cells of certain vulnerable areas of the brain. It is characterized by nerve-cell loss, abnormal tangles within nerve cells and deficiencies of several chemicals, which are essential for the transmission of nerve messages.

The disorder leads to behavioral and personality changes, forgetfulness, confusion, inability to learn new material, paranoia and motor activity problems. Language difficulties also are common in people with Alzheimer's disease. The disease typically progresses to the stage where it is difficult for the patient to be understood by others or to understand others, and in the final stages, the patient is bedridden.

Although nearly half of those over 85 may have Alzheimer's disease, it is not a “normal” part of aging.

Causes and Risk Factors of Alzheimer's Disease

The cause of Alzheimer's disease has yet to be determined, but there are five (5) theories that warrant further investigation:

1. Chemical Theories

   A. **Chemical Deficiencies**. One of the ways in which brain cells communicate with one another is through chemicals called neurotransmitters. Studies of Alzheimer's diseased brains have uncovered diminished levels of various neurotransmitters that are thought to influence intellectual functioning and behavior.

   B. **Toxic Chemical Excesses**. Increased deposits of aluminum have been found in Alzheimer's disease brains.

2. **Genetic Theory**.
   Researchers have linked late-onset Alzheimer's to the inheritance of a gene that directs production of apolipoprotein (ApoE). In early-onset Alzheimer's, researchers identified a mutation on chromosome 14, which accounts for 10 percent of Alzheimer's cases. Additionally, a mutation was found on chromosomes 1 and 21. In 1997, researchers found another mutation on chromosome 12 that is linked to late-onset Alzheimer's.
3. **Autoimmune Theory**.
   The body's immune system, which protects against potentially harmful invaders, may erroneously begin to attack its own tissues, producing antibodies to its own essential cells.
4. **Slow Virus Theory**.
   A slow-acting virus has been identified as a cause of some brain disorders that closely resemble Alzheimer's.
5. **Blood Vessel Theory**.
   Defects in blood vessels supplying blood to the brain are being studied as a possible cause of Alzheimer's.

The chances of getting Alzheimer's disease increases with age and usually occurs after the age of 65, after which the chances of getting the disease double every five years.

There are only two definite factors that increase the risk for Alzheimer's disease before age 65: a family history of dementia or Alzheimer's, and Down syndrome. Down syndrome is a combination of physical abnormalities and mental retardation characterized by a genetic defect in chromosome pair 21.

Symptoms of Alzheimer's Disease

The U.S. Agency for Health Care Policy Research provided this list of questions to help recognize the condition:

- *Learning and retaining new information*. Does the person misplace objects and/or have trouble remembering appointments or recent conversations? Is the person repetitive in conversation?
- *Handling complex tasks*. Do familiar activities like balancing a checkbook, cooking a meal, or other tasks that involve a complex train of thought, become increasingly difficult?
- *Ability to reason*. Does the person find it difficult to respond appropriately to everyday problems, such as a flat tire? Does a previously well-adjusted person disregard rules of social conduct?
- *Spatial ability and orientation*. Does driving and finding one's way in familiar surroundings become impossible? Does the person have problems recognizing familiar objects?
- *Language*. Does the person have difficulty following or participating in conversations? Does the person have trouble finding the words to express what they want to say?

- *Behavior*. Does the person seem more passive or less responsive than usual or more suspicious or irritable? Does the person have trouble paying attention?

The onset and symptoms of Alzheimer's disease are usually very slow and gradual, seldom occurring before the age of 65. It occurs in the following three (3) stages:

Stage 1: forgetfulness, poor insight, mild difficulties with word-finding, personality changes, difficulties with calculations, losing or misplacing things, repetition of questions or statements, and a minor degree of disorientation

Stage 2: memory worsens, words are used more and more inappropriately, basic self-care skills are lost, personality changes, agitation develops, can't recognize distant family or friends, has difficulty communicating, wanders off, becomes deluded, and may experience hallucinations

Stage 3: bedridden, incontinent, uncomprehending, and mute

Diagnosis of Alzheimer's Disease

An estimated 5 to 10 percent of all mental deterioration in persons over the age of 65 is due to reversible conditions, such as depression, underlying physical disease (metabolic disorders, cardiovascular disease or pernicious anemia), excessive and inappropriate drug use, loss of social support, or change in social environment. Therefore, it is important to diagnose Alzheimer's disease to ensure that any mental impairment is not reversible.

In order to diagnose Alzheimer's disease, a physician must:

- take a detailed medical history
- conduct physical and neurological examinations
- consult the diagnostic criteria stated below
- conduct laboratory examinations, such as urine tests, a CAT scan, magnetic resonance imaging (MRI), or positron emission tomography (PET) to detect structural abnormalities of the head and brain
- conduct a functional and mental status assessment test
- do a complete inventory of any prescription and over-the-counter drugs the patient is taking

The diagnostic criteria for dementia and Alzheimer's disease is as follows:

Dementia

A. Multiple cognitive deficits manifested by both 1 and 2:

1. Impaired short- or long-term memory
2. One or more of the following cognitive disturbances:

- Impaired language ability
- Impaired ability to carry out motor activities
- Impaired ability to recognize objects
- Impaired abstract thinking (e.g., planning and organizing)

B. Deficits in A are sufficient to interfere with work or social activities and represent a significant decline in function.

C. Deficits do not occur exclusively during the course of delirium.

Alzheimer's disease

Dementia as determined by A through C (stated above), plus:

D. Disease course is characterized by gradual onset and continuing cognitive decline.

E. Cognitive deficits are not caused by any of the following:

- Another progressive central nervous system disorder (e.g., Parkinson's or Huntington's disease)
- A systemic condition (e.g., hypothyroidism or niacin deficiency)
- A substance-induced condition

F. Disturbance is not better explained by another disorder (e.g., major depressive disorder or schizophrenia).

Treatment of Alzheimer's Disease

Although there is currently no cure for Alzheimer's disease, a great deal can be done to manage it. There are four (4) approaches to managing the disease. The approaches and solutions are:

- Relieve behavioral symptoms associated with dementia, including depression, agitation and psychosis. Medications, called cholinesterase inhibitors, such as tacrine (Cognex), donepezil (Aricept), rivastigmine (Exelon) or galantamine (Reminyl), enhance the effectiveness of acetylcholine (the chemical messenger found in the neurotransmitter system which coordinates memory and learning) by slowing its breakdown. Unfortunately, these medications only temporally improve the symptoms associated with Alzheimer's. The effects of the drugs will fade as the deterioration of brain cells progresses. More recently, memantine (Namenda) was approved by the FDA. Memantine blocks the effects of a different chemical, glutamate, which is felt to overstimulate nerve cells and cause their degeneration. Additionally, doctors may prescribe antidepressants, antipsychotics, anticonvulsants, beta blockers, benzodiazepines, serotonin reuptake inhibitors, and drugs such as Desyrel, BuSpar, and Eldepryl, to control the agitation,

psychosis, depressive features, anxious features, apathy, and disturbances in sleep and appetite.

- Relieve cognitive dysfunction to improve memory, language, attention, and orientation. Doctors may prescribe precursors, cholinesterase inhibitors, and cholinergic receptor agents.
- Slow the rate of illness progression, thereby preserving quality of life and independence.
- Delay the time of onset of illness. Medications and therapies to combat these problems are still in the development and clinical trial stages. For instance, the research shows that vitamin E slows the progress of some consequences of Alzheimer's for about 7 months, and scientists are investigating whether ginkgo biloba can delay or prevent dementia in older people, and if estrogen can prevent Alzheimer's in women with a family history of the disease. Researchers are looking at methods to enhance cerebral metabolism, stabilize membranes, promote neuronal sprouting, decrease inflammation, neurotoxins and excitatory amino acids, as well as alter metabolism of key proteins.

In addition to the pharmaceutical approaches, conservation methods also can be beneficial to the management of Alzheimer's disease, such as:

- eating a proper diet
- getting daily exercise
- continuing intellectual stimulation and social contact
- implementing memory aids, such as a prominent calendar, lists of daily tasks, and labels on frequently used items that can help compensate for memory loss and confusion
- providing a comfortable and stimulating environment and always trying to give simple and easy to understand instructions
- participating in support groups

http://scc.healthcentral.com/bcp/main.asp?page=ency&id=100&ap=445&brand=30#Symptoms

Care of Client with Alzheimer’s Disease

As the disease progresses, your loved one's personality, abilities, and moods may change. As you help the person, be patient and always look for new ways to do things. Something that worked one day may not work the next.

Getting Dressed
Clothing is a good way for a person to express themselves. Looking good can make a person feel better. That's why it's important to think about what the person likes and what they don't like.

- Don't rush the person. Be flexible. If the person wants to wear the same outfit over and over, try getting more than one of the outfit or get ones that are similar.
- Make sure clothing is simple and comfortable. Shirts or sweaters with buttons in front are easier to wear than pullover tops. Also, larger clothes may be easier for the person to put on.
- It's common for someone with Alzheimer's to wear layers of clothing. Try not to worry. If they are too hot, they will remove some of the items.
- People with Alzheimer's sometimes don't like to change their clothes. In this case, dress them in clothes that can be worn during the day and to sleep at night.

Eating Meals
Eating problems are often seen in people with Alzheimer's as the disease progresses. In the beginning, you may see changes in the person's appetite. What they like to eat may change as well. Sometimes there will be weight loss, overeating, or trouble with eating. To encourage people with Alzheimer's to eat, some simple changes can be a big help. Snacks between meals can help increase weight. A change in mealtime routines, such as playing soft music, has also been shown to keep people at the dinner table longer.

To help, make changes in how food is served:

- Take away pits, bones, peels, or wrappers. Food should be able to go straight from the plate to the mouth.
- Reduce distractions such as the phone or television during mealtime.
- Serve foods that can be eaten easily, or with their hands.
- Add different textures and color to food. It will help keep your loved one interested in what they're eating.

Driving
Alzheimer's affects many of the functions that a person needs to drive safely. It is important for families to think about the issue of driving and talk about it with the doctor. If you notice any of the changes below, you should consider stopping your loved one

from driving right away.

Being confused:

- Getting lost
- Forgetting to use turn signals
- Confusing the brake pedal and the gas pedal
- Being confused about directions or detours

Driving unsafely:

- Hitting the curb while driving
- Failing to yield
- Problems with changing lanes or making turns
- Driving at the wrong speeds

If you need to tell your loved one that (he/she) can no longer drive, it is important to be sensitive. Remember, Alzheimer's disease affects the ability to reason. Don't try too hard to convince the person. A simple statement may be best. If you can't get the person to stop driving, here are some things you should consider:

- Have your doctor call the State Department of Motor Vehicles to ask that (he/she) take a driver's test.
- Try other ways to get around such as buses, taxis, senior vans, family, and friends.
- Check with your local Alzheimer's Association to learn about transportation options in your community.

Dental Care
Good dental care can be hard for people with Alzheimer's. Brushing is sometimes hard because the person can't understand or won't accept help from others.

- Keep instructions short. Like "hold your toothbrush," "put paste on the brush," "brush your top teeth," and so on.
- Show them how to do it. Hold a brush and show the person how to brush their teeth. Try to brush teeth or dentures after each meal and make sure they floss every day. Also remove and clean dentures every night. While the dentures are out, brush the person's gums and roof of the mouth.
- Caregivers are key in helping the person have good dental care. They are the ones most likely to notice any problems. If you notice a problem, talk to the dentist right away. Tell the dentist that the person has Alzheimer's, so they can create a special routine.

Bathing
Bathing is often the hardest personal care task that caregivers face. Because it is so private, the person with Alzheimer's may feel embarrassed or threatened.

- Do what you can ahead of time, such as making the room warmer and having bath towels nearby. Some people may not like to be undressed by someone else. In this case, wrap a towel around their shoulders to add more privacy.
- Make the person feel in control. Involve and coach him or her through each step.
- Create a safe and pleasing atmosphere. Place non-slip adhesives on the floor surface. Put grab bars in the bathtub to prevent falls. Test the water in advance to prevent burns. Set the water heater to 120 degrees to avoid burns.

Using the Bathroom
Often, people with Alzheimer's have trouble using the bathroom. They may have loss of bladder and/or bowel control. It can be caused by many things. Some of these can be medicines, stress, a physical condition, and the environment.

- Make the bathroom easy to see. Post signs that read "toilet" to help someone find the bathroom. Keep the door open and a light on, especially at night.
- Watch for signs the person you care for has to use the toilet. Track how often they go to the bathroom, and take them to the bathroom ahead of time.
- Make sure clothes are easy to put on and take off, for using the bathroom.

Be supportive. Help the person with Alzheimer's keep a sense of dignity. Reassure them. It will help them be less embarrassed.

Home Safety with Alzheimer Clients

There are a lot of simple steps you can take to make the home safer for someone with Alzheimer's. Here are a few tips you can use.

Make it Easier to See

- Add lighting in places between rooms, stairways, and bathrooms. Changes in levels of light can be confusing.
- Place different colored rugs in front of doors or steps to help the person expect staircases and doorways.

Make Daily Activities Safer

- Watch over the person when he or she is taking any medications.
- Close off all items or areas that could be a danger. Use locks and child safety latches.
- Clean out the refrigerator. Take out all food that may be spoiled.
- Limit the use of equipment that could be a danger (Such as stoves/ovens, grills, toasters or knives).
- Try to get appliances that have an automatic shut-off. This can help prevent burns or fires.

Be Ready for an Emergency

- Keep a list of important phone numbers at hand. (Such as numbers for police, and fire, as well as the doctor, hospital and poison control.)
- Check fire extinguishers and smoke alarms. Have fire drills often.
- Consider signing up for the Safe Return Program at http://www.alz.org/Services/SafeReturn.asp. This is a nationwide program that helps those with Alzheimer's get home safely if they wander off alone.

Complex Assessment Situations (Mental Illness)

In-Home Supportive Services Training

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AUGUST, 2005

How To Effectively Identify The Need For Assistance In Daily Activities Among People With Mental Disorders

How To Effectively Interact With People With Mental Disorders

Introduction

What is a mental illness? It is defined by the American Psychiatric Association as being a "clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with a significantly increased risk of suffering death, pain, disability, and/or important loss of freedom" (APA, 2000).

A mental disorder, like a physical impairment, can have a significant impact on an individual's ability to conduct activities of daily living. As an IHSS worker, you may have had difficulty determining functional impairment for IHSS of a person with a mental illness and deciding which tasks to authorize. You know that assistance with shopping, cooking, bathing, and accompaniment to medical appointments is not only relevant to those who have physical handicaps. Those who experience severe symptoms of depression, schizophrenia or other mental disorders may exhibit impairments in Domestic, Related and Personal Care areas similar to those with limited mobility and dexterity caused by severe arthritis. And just like those with physical impairments, people with mental disorders have a range of symptoms. Two individuals diagnosed with major depression may exhibit different deficits. One person with depression may not have enough energy to pay his/her bills while another person may not even have enough strength to eat regularly. In addition, a mental disorder such as depression can be related to a physical condition. For instance, someone who can not go shopping because they are physically disabled may also be depressed because of the impairment. As a consequence, this person's depression may affect their ability to do simple tasks such as cooking and grooming.

There is great stigma attached to mental illness. Much of society believes that mental illness can be "overcome through 'will power' and is related to a person's 'character' or intelligence" (National Alliance for the Mentally Ill, n.d.). Though society doesn't blame a person for his/her cancer, many with a mental disorder are blamed for their condition that likewise holds them captive to their illness. More than 54 million Americans, in any given year, have a mental disorder. However, less than 8 million seek out help (National Mental Health Association, n.d.). Although some may not recognize that they have a problem, others may not want to deal with the reaction others may have towards them.

They may feel that others will judge them and make them feel like they should have more control over their actions. People with mental illnesses may be ashamed of their conditions, believing that they are weak if they seek out treatment. Therefore, you may get a medical report that does not mention a severe mental illness the consumer is experiencing.

Substance Abuse and Mental Illness It is also important to recognize that drug and alcohol use may be associated with mental health issues. It is estimated that around 15% of adults who have a mental illness also have a substance abuse problem (National Mental Health Association, n.d.) A person who use substances is in many ways self medicating. The psychological pain associated with a mental disorder can be tortuous. A drug or a drink may seem like the only solution to quell this pain. You may have preconceived notions about drug use or alcohol abuse. You may have a relative or friend whose substance use had a negative impact on others. Having a client who drinks heavily may bring up strong emotions, possibly from personal experience. It is important to realize that this is happening, and that it is normal to have these feelings. However, if you do not recognize them, your feelings about mental disorders and drug/alcohol use will hinder you from providing good service.

As IHSS workers, you are in the unique position of engaging people in a non-judgmental manner. While your comsumer may have been turned away by families and friends because of their behaviors, you are a fresh face. It is crucial to accept people where they are. If the IHSS applicant or consumer believes that you are hold judgments against them, they will not want to work with you, affecting your ability to provide services. If you have difficulty working with a client because of certain personality or substance use issues, you should get support from your supervisor or a counselor through your work. These personal feelings can lead to burnout or apathy which neither helps you nor your client.

Schizophrenia

Schizophrenia affects more than 2.5 million Americans, or 1% of the population (National Mental Health Association, n.d.). Schizophrenia, like other disorders, affects many individuals differently. However, it is common for people with schizophrenia to exhibit what is known as positive and negative symptoms (American Psychological Association, 2000).

Positive symptoms are also referred to as psychotic or active symptoms. These include delusions, hallucinations, disorganized thinking, and disorganized behavior. Delusions are false personal beliefs that go against what other people believe. They may be persecutory, grandiose or religious beliefs. Someone may believe a neighbor is spying on them, looking through a crack in the wall. Someone else may believe that they are being sought after by the police or their landlord for some imagined action. A person may think that they have direct communication with the President or God. Delusions of any kind occur for 90% of people with the disorder (Schizophrenia Fellowship, n.d.).

Hallucinations can be associated with any of the five senses. However, auditory hallucinations are the most common. These auditory sensations usually come in the form of voices that are often criticizing a person or commanding them to do something. Hallucinations of any kind occur for 70% of people with schizophrenia. Disorganized thinking is usually manifested in how a person speaks. His/her speech is disjointed and lacks coherent structure, jumping from one subject to the next. Disorganized behavior can cause deficiencies in activities of daily living. This behavior may be demonstrated by aimless wandering, talking to oneself in public, or wearing many clothes on a hot day (Schizophrenia Fellowship, n.d.)

Negative symptoms relate to a loss of normal functioning. They include withdrawal or loss of motivation, inability to feel pleasure, lack of verbal speech, or a flat affect. Therefore, people with schizophrenia may lack energy to do daily activities such as grooming, household chores, or cooking. A person with schizophrenia may also be socially isolated, finding it difficult to have close friendships. They may also have a great reduction in an ability to respond to questioning, speaking very little. In addition, they have little eye contact or have flat facial features (Schizophrenia Fellowship, n.d.) Medications meant to treat the symptoms of schizophrenia may also cause a person to feel a lack of physical or mental energy (Nathan, Gorman & Salkind, 1999, p. 170). Depressive symptoms can also be related to people with schizophrenia. They have greater rates of suicide than the general public (NetDoctor, n.d.). In the next section on depression, suicide risk will be discussed in greater detail

IHSS Functional Limitations

As a person's symptoms get worse, his/her ability to function normally in society deteriorates. Concentration or getting sleep is difficult. He/she may spend more time alone. Because of symptoms such as hallucinations or delusions, a person may find it difficult to carry out normal daily tasks. He/she may be so consumed by his/her delusion or hallucination that it would be difficult to clean, shop, or pay bills (Hales & Hales, 1995, p.416). If a person has a delusion that their landlord is trying to spy on them or evict them, he/she may not pay their rent, actually putting them at risk for eviction. Another person may have a delusion that turning on the stove may start a fire, causing them not to cook.

Having disorganized behaviors can lead to difficulties in activities such as bathing, grooming or cooking. People wearing multiple layers of clothes or having outbursts in public may not have the ability to understand how to turn on a stove or clean their apartment. Besides having disorganized behaviors, those with schizophrenia may be too apathetic to clean their rooms. They lack the energy to dress properly or to shower (Schizophrenia Fellowship, n.d.).

IHSS can assist in providing needed services such as domestic, laundry, shopping, and meal preparation. Although a person with schizophrenia may be unimpaired physically, their deficits in ADLs may be severe. Without assistance in these activities, a person may be at risk of eviction or health and safety hazards.

Techniques in Interacting with People with Schizophrenia

As an IHSS worker, you assess the person's home care needs, authorize services and implement a case plan so consumers can live safely in their home. Without the right approach to a client, those tasks may become difficult or impossible. When interviewing a person with schizophrenia, it is best to use short sentences, speaking calmly (Woolis, 1992). People with schizophrenia may have difficulties in processing a lot of information. It is important to speak calmly and slowly, so as not to cause alarm or tension in the client.

It is helpful with someone with schizophrenia to limit the amount of distractions in a room. Ask to turn off a TV, radio or some other appliance making noise (HealthyPlace, n.d.). Be mindful of your distance and position to client. Stand to a person's side rather than forward. Give a person a few feet distance, especially if they seem upset. Be mindful of your tone of voice. Never shout to get attention, and avoid close and direct eye contact if a person seems to be very upset (HealthyPlace, n.d.) And if the client's anger seems to be escalating, excuse yourself and leave.

When interviewing someone with schizophrenia, do not always expect rational discussion. Keep your discussions simple, repeating your questions or comments. It is also good to get a client to repeat or paraphrase what you are saying, possibly stating, "Just so I know that we are clear on what we are working on, can you tell me what you think I am asking?" Do not overburden a client with too much information. Focus on the necessary facts and questions. If you feel that the client is tired or anxious, you might ask if the client wants to take a break.

If a client talks about delusions or hallucinations, do not argue with them. You will not be able to convince them that these delusions are not real. However, you should not pretend that you see or experience the same delusions. You might say, "I see how terrible it must be to experience that". If a client asks if you see or hear the same thing he/she does, do not be afraid to say you do not. However, use empathy, concentrating on validating their experience and how painful or difficult it is for her/him. If someone does not believe that you care, they will not want to work with you.

It is important to remember that people with schizophrenia or severe depression may not be able to ask for help. In fact, they may have pushed a lot of people away from helping them. They can feel vulnerable and afraid, not wanting people involved in their lives. Do not take it personally if someone gets upset with you or is difficult to get along with. This defensiveness is because of the fear and mistrust they feel. After the client establishes a relationship with you and knows he/she can trust you, subsequent meetings will be easier.

Do not expect to get all the information you want in the first interview. Especially if a person is actively experiencing or relating to you hallucinations or delusions, they will be more preoccupied with that then what you have to offer. If a person is telling you in a haphazard way how a neighbor or landlord is spying on them, or how people come in his/her room in the middle of night, just listen. Be non-judgmental. Initially, do not

interrupt. Just let the person talk through what he/she wants to. Non-verbal communication can be more powerful than interrupting and saying something that you feel would help.

Sometimes it can be difficult to get needed information from a client with schizophrenia. He/she may ramble on or have disjointed speech that is difficult to redirect. To bring forth your clear and concise information, you might need to interrupt. A good approach is to say, "That sounds really awful", or "that sounds really interesting", and then recap or reframe what they were saying, repeating it back to them. This gives him/her a chance to feel heard, but also give you a chance to move on. During some points of an interview, you may need to be directive, giving or getting needed information. However, never be confrontational or argumentative. When someone is in an acute psychotic state, rational discussion can not exist.

Violence Most people with schizophrenia are not violent. For the most part, they are withdrawn from society, preferring to be alone (HealthyPlace, n.d.). However, it is important to keep in mind that people with schizophrenia, like non-psychotic people, may have outbursts that could put you in harm's way. One study notes that individuals with schizophrenia may have a difficulty in reading facial expressions. Therefore, if you are arguing with someone with schizophrenia, they may believe your intentions are more hostile than they actually are. While you may be just arguing a point, this person may believe you are trying to provoke a fight (Arehart-Treichel, 2005).

When you visit a client, you should be mindful of exit ways. If a client becomes loud or aggressive and you feel this situation could be dangerous, do not question leaving the interview. Your safety comes first.

Finally, if a person expresses a desire to harm himself/herself or another person, take these threats seriously. If he/she appears calm, try and get detailed information about how he/she may do this and who his/her intended victim is. Do not argue with the person, especially if he/she appears angry and upset. Politely excuse yourself from the interview, notifying your supervisor and possibly the police for evaluation.

Depression

Depression is one of the most common mental disorders. A person can be depressed because of a death in the family, a loss of income, or a divorce. Most people have gone through some time in their life where they have felt depressed or sad. However, it is important to distinguish between a time-limited depression and a major depressive disorder, which is ongoing. Contrary to society's general belief, a person with major depressive disorder can not will themselves out of that condition. Even with therapy, medication, and exercise, a person may still be depressed. Many intelligent and successful people suffer from major depression. For the population you work with, depression can be especially prevalent since people are being influenced by loss of functioning, environmental and financial factors. As with other mental disorders, drug or alcohol use may be used as self medication and as an escape from the socio-economic and psychological perils a person is experiencing.

A major depressive disorder is characterized by having a depressed mood for most of the day for nearly every day. This depression can be observable by other people, noticing the person may be tearful or even irritable. The person has limited interest in activities and he/she may have difficulty sleeping or may be sleeping to an excessive amount. A person may have a loss of appetite which causes weight loss, have difficulty concentrating, and have a diminished ability to make decisions. A person may also have feelings of worthlessness or express excessive guilt about a certain action. In addition, they may appear to either be physically restless or slowed down (American Psychiatric Association, 2000).

Physically, a person who is depressed may have poor posture, walking with a slow gait. They may speak slowly and softly, not having eye contact. They may understate their need for help, not wanting to bother you, feeling ashamed about their depression. Particularly with elderly clients, it may be difficult to recognize if they are depressed. Some elders have slow or poor ambulation due to age. Unfortunately, an elder may be seen as being demented before they are seen as being depressed. An elder's memory can be affected by depression, which can mimic dementia symptoms. However, with most depressed elders, unlike elders with dementia, they will more often complain of memory problems (Kansas State University, n.d.).

Also because of the stigma with mental illness, especially for an older generation, elders may not be forthcoming about being depressed. Depression can be expressed through physical complaints, either imagined or real. A client may describe problems with sleeping or lack of appetite, which can be signs of depression. Unlike most people with dementia, a depressed elder's engagement in the conversation may seem impaired (Kansas State University, n.d.). One important similarity to bear in mind is that demented and depressed elders can both have severe limitations in their ability to conduct activities of daily living.

Depression can also take unexpected forms. You may imagine a depressed person as being sullen and tearful. However, someone who is depressed may also be aggressive

and angry. He/she may direct his/her anger at you, saying you are not helping enough or that you don't care. Or, they may express anger at their living situation or relationships with other people. It is important to understand that people who are depressed may have significant problems in relating to others. They may express their sadness or despair through anger.

In the section involving how to interact with depressed individuals, there will be a discussion about suicide risk. People experiencing depression should be asked about suicidal intent. Although this is beyond questioning and assessing for IHSS needs, it is crucial information to be gotten. You may be the only person this client has interacted with or has discussed depression with. Therefore, you are in a unique position to assess for suicidal risk and your actions may save this person's life.

IHSS Functional Limitations

As with schizophrenia, people with depression may exhibit different levels of functional ability in activities of daily living. A mildly or moderately depressed person may be able to function well in society, having a full time job. A person with severe depression however, will have marked impairment in their activities of daily living. Of course, this is a consequence of the disorder and not within his/her ability to control.

In one German study, researchers found that depressed elders were twice as likely to have problems with toileting, dressing, grooming, getting out of bed, cutting food, and taking medication as non-depressed elders. In addition, these depressed elders were twice as likely to have difficulties in handling their finances, shopping, cleaning house, or visit their doctor as non-depressed elders (Braune & Berger, 2005, p.178).

Because of a loss of energy and diminished ability to concentrate that is inherent in depression, daily tasks can become unbearable. A simple change of clothes can seem impossible. Preparing a meal or cleaning an apartment can be monumental. If your client spends most of his/her time lying in bed or pacing in his/her apartment, his/her ability to shop or cook for himself/herself is probably poor. Depression can be a never ending cycle. If a person is living in poor physical conditions, his/her inability to correct this can make him/her feel more depressed. A regular visit by an IHSS provider can not only provide needed human contact, it can also make a person feel better when his/her living space is cleaner.

Techniques in Interacting with People with Depression

Though your job as an IHSS worker is not to provide therapy to a client with depression, you can provide real support and engage a person in a way that can better help you provide services. As in your work with any client, your first job is to establish rapport. Having rapport is gaining a mutual understanding or agreement between two people. Most importantly, this means that you and your client need to agree that you can both work together, and that he/she knows that you can serve him/her.

Establishing this rapport includes many steps. First, you should be friendly and non-judgmental. You should also not appear hurried, showing that you have time to spend

with this person. You should define what confidentiality requirements you have with them, as well as what the limitations to confidentiality are. Interview the person alone, making sure that your meeting space gives the client a safe space to talk. Before talking about sensitive issues such as medical or psychological history, ask this person's permission (National Health and Medical Research Council, 2004). This will make him/her feel like you respect him/her more; consequently, it makes him/her want to reveal more. And most importantly, listen to the client. Listen without judging. If there are moments where you can offer praise or positive feedback, do this as well.

Listen without having to feel like you need to respond to a person's comments by saying something like, "Everything will be okay". For a client who is depressed, this reassurance will sound hollow and lacking in empathy. A simple non-verbal gesture of understanding or statement like "I hear what you are saying, that must be really hard to be going through that" can make a positive difference. Remember that with empathy, you are better able to understand how the environment, socio-economic factors, and loss that impacts his/her mood and his/her ability to adequately perform activities of daily living.

Suicide If you assess or are told by a client that he/she is depressed, you will want to question more. Although it may feel unnatural to do so, you should ask about any suicidal feelings. Some may feel that by asking about this, they are giving a client the idea to commit suicide. That is not true. Questions about suicidal intentions will not give a person any ideas that he/she did not already have (Preskorn, n.d.). In fact, it will probably be a relief to him/her that you care enough to ask about it.

Risk factors for suicide include being male, being older, having previous suicide attempts, using alcohol, having a lack of social support, having a medical sickness, lacking a significant other, and having a plan for committing suicide (Preskorn, n.d.). In questioning them about suicide you can say, "You sound as if you have been feeling pretty miserable. Has life ever seemed not worth living?" (Preskorn, n.d.) Or, you could simply ask your client if he/she has ever felt suicidal before.

After determining that this person has felt suicidal, you will want to ask if these feelings are recent. Then you will want to ask if he/she has thought about acting on these thoughts. A client may say, "I wouldn't actually do it" or "I would never do it, it's against my belief system". If a person states that they have thought about acting out suicidal thoughts, you should question if they have plan. If they do have a plan, ask what it is (Preskorn, n.d.). If a person describes the plan, ask if they have means to execute this plan. If a person plans on shooting himself/herself, this may be less risky than someone who plans to overdose on medications, if he/she does not have access to a gun.

If the person has a plan and has the means to carry it out, ask when he/she plans on doing this or if he/she has already started carrying out the plan, like overdosing. Even if the level of suicidal risk seems low to you, you should still consult with your supervisor. However, if the risk of suicide appears imminent, you may need to intervene by calling your supervisor and the police or a mental health specialist.

Hoarding Behaviors

Because of the nature of IHSS, you have probably encountered clients who have hoarding and cluttering behaviors. This kind of behavior can occur at any age, but it may be related to more than just obsessive-compulsive tendencies as a person ages. Although hoarding and clutter may not require emergency interventions, it can still pose a serious danger to a person's safety. It can also be a health hazard for others living around him/her.

Older adults have been found to hoard items that they perceive as being valuable or that provide a source of security. They may have a fear of losing items or have physical limitations which hamper their ability to organize. They may have experienced stressful events such as the Great Depression, when material goods were scarce (LA County Department of Mental Health, n.d.). An overarching theme is that these items replace intimate relationships or friendships. They provide a comfort zone from the outside world that may appear threatening. Throwing out a piece of clutter can seem to a person like a piece of him/her is being thrown out.

You may be tempted to call a client's clutter "junk" or "trash". Although it may appear like trash to you, it is precious goods to the client. However, a client may perceive that you may think their clutter is "junk", being skeptical of letting you in. Again, you must show that you are non-judgmental and that the condition of his/her apartment does not bother you. Use a very gentle approach, not expecting them to throw out clutter in one visit.

Safety evaluation You should evaluate for a client's ability to ambulate and open doors around the clutter. You should also see if the clutter is near ovens or electrical outlets, posing a fire risk. Clutter may also be obstructing a client's ability to take shower or go to the bathroom. An appeal to have things moved around because of safety reasons may have some success. Over time, a Provider may be able to work with the client in getting rid of small portions of clutter. A hasty intervention may cause the client to become anxious and very depressed. For elders, hoarding behavior like drug use, can serve as a coping mechanism for depression (Dunn, 1995).

Techniques in Interacting with People who Hoard

Success with hoarding behavior can be difficult. One author notes that the only successful interventions involve "social pressure and legal process" (Dunn, 1995). This means that some people will only change if forced to, by either the Health Department or by risk of eviction. This threat can be a motivating factor in decreasing the client's clutter. By focusing on the client's risk to health and safety or possible loss of housing, he/she may be more willing to accept services. It is important not be confrontational when raising these risks. However, if your assertiveness comes from an empathetic and caring position, a client will be more likely to work with you. Also, if you feel that the client's hoarding behaviors pose a serious health and safety risk to himself/herself or others, you should consult with your supervisor and/or make a referral to an appropriate mandated reporting agency, e.g. Adult Protective Services.

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Schizophrenia

Characteristics

- Schizophrenia affects around 1 percent of the American population.
- Schizophrenia consists of "positive" and "negative" symptoms.
- Positive symptoms refer to active symptoms, including delusions, hallucinations, disorganized thinking, and disorganized behavior.
- Negative symptoms refer to a loss in functioning, including withdrawal or lack of motivation, inability to feel pleasure, lack of verbal speech, or flat affect.

IHSS Functional Limitations

- Concentration or sleep can deteriorate, causing problems with simple tasks such as cooking, cleaning, or shopping.
- The delusions or hallucinations a person with schizophrenia experiences can consume all their energy, causing them to have problems with cleaning, shopping, or paying bills.
- The "negative" symptoms of schizophrenia can cause a total lack of motivation in doing cleaning or dress changes.
- Delusions like feeling a landlord is trying to evict him/her may trigger the client to not pay rent, actually putting him/her at risk for eviction.
- The client may have delusions about certain items in the home, believing that turning on the stove may cause a fire, causing them not to cook.

Techniques In Interacting With

- Use short simple phrases when asking questions or giving information.
- Use a calm and unhurried tone of voice.
- Never shout or try to argue with the client. Rational discussion will not be possible of the client is acutely psychotic.
- Give the client some physical space and try to avoid too much direct eye contact.
- If the client is tangential, politely interrupt by recapping what he/she said, and then move on to your questioning.
- Never be judgmental or put blame on the client for their condition. Do not try and convince the client their delusions or hallucinations are fake. However, do not go along with it, pretending you are experiencing them as well. Be empathetic by expressing your understanding of how the client feels because of these delusions/hallucinations.
- Turn down unnecessary noises in the apartment.
- If the client can not calm down and appears very angry, excuse yourself politely and leave.

Depression

Characteristics

- Client appears sad or tearful.
- Client's posture, gait, and speech are slow. The client may also have a decreased tone when speaking.
- Alcohol/drug use may be present.
- The client may complain of restlessness or sleep deprivation.
- The client may show excessive weight loss or weight gain.
- The client may express feelings of excessive guilt or worthlessness.
- Although a depressed person will appear sad, they may also exhibit anxiousness or anger.
- The client has probably lost interest in activities that were once pleasurable.
- The client may complain of memory problems or difficulty concentrating, especially if they are older.
- The client may have a loss of energy or have fatigue.
- The client lives alone and/or was close to someone who recently passed away.
- The client may talk about death or express suicidal thoughts.

IHSS Functional Limitations

- Because of a lack of concentration, tasks such as bill paying, or shopping can be difficult.
- A client's sense of worthlessness or apathy can affect their ability to want to be clean or keep his/her dwelling clean.
- Depression can cause a lack of appetite and a desire to cook meals.
- Severe depression will make it difficult for a client to even get out of bed.

Techniques In Interacting With

- Develop rapport by showing that you are willing to spend the time to listen to your client. Show empathy and understanding by putting yourself in your client's shoes.
- Do not blame the client for his/her depression. Separate the disorder from your client. Do not expect a client to be able to do household tasks if they are depressed, even if they appear physically able to do so.
- Do not offer empty promises like "things will be okay". Listen to the client. It is okay not to have advice. The best thing you can do is show that you care enough to listen. This can be done without even talking.
- Give you and your client a private place to talk.
- Establish trust by explaining confidentiality rules.
- Assess for suicide risk by asking if the client has thought about harming himself/herself before. If so, ask if this is recent, does he/she have a plan and the means to carry it out.

Hoarding

Characteristics

- Hoarding behavior can occur at any age, but may be related to more than just obsessive-compulsive traits as a person ages.
- Elders have been found to hoard due to a fear of losing items, having physical limitations, having organizing problems, or using items as a psychological replacement for loved ones and friends who have passed.
- Elders may also hoard due to generational concerns, such as surviving the Great Depression.
- Throwing away a client's clutter can be psychologically damaging to the client, feeling like a part of himself/herself is being thrown away. Hoarding behaviors may serve as a coping mechanism against depression, like drugs or alcohol.

IHSS Functional Limitations

- Hoarding behaviors can limit a person's ability to ambulate, causing blockage to walkways and doorways.
- A client who hoards may store items in the bathroom, making it difficult or impossible to bathe or use the toilet properly.
- A client who hoards may also obstruct ovens and stoves, making it difficult to cook, the clutter also becoming a fire hazard if the client attempts to cook. The client may also have a refrigerator stacked with rotten food and liquids.
- As people age, they may have difficulties with ambulation. The fall risk for elders living in these environments can be very high.

Techniques In Interacting With

- Refrain from calling a client's clutter "junk" or "trash". These items are psychologically very valuable to the client.
- Approach the client with respect and non-judgment, showing that you do not mind the condition of the apartment. Use a gentle approach, especially when you first meet the client, not expecting them to immediately throw out their clutter.
- The in-home worker who is assigned may be able to convince the client to throw away small portions of clutter over time, or move it to help the client shower or cook. The client should be involved in this process.
- One author notes that only "social pressure and legal process" has been successful with hoarding behaviors. Therefore an appeal to the client's safety and/or risk of eviction may be helpful motivating factors.
- After establishing trust, using assertiveness can be helpful. A client will probably not throw clutter out on their own. Be assertive, yet caring, focusing on a risk for falls, safety hazards, threat of eviction, or threat of public health involvement with the client.
- Consult with your supervisor and/or make a referral to Adult Protective Services or appropriate mandated reporting agency if clutter becomes a great risk to the client.

Mental Illness Scenarios

Case Example -Schizophrenia

Robert is 50 year old male who is living independently in a small apartment, with shared bathrooms, showers and communal kitchen down the hall. The client, who is diagnosed with schizophrenia, has delusions about other residents. He thinks that some are spying on him through a crack in his front door, which he has duct taped. He also believes that one resident would try to poison his food if he tried to use the microwave down the hall. About a month ago, he got into a verbal argument with this person, the other resident spitting at the client, calling him a "crazy @#$%". The client also has auditory hallucinations, believing that someone is in his room telling him that he is "worthless" and "stupid".

The client's room consists of unorganized piles of fast food wrappers and other trash. The client's mattress has a major dent in the middle and it appears to have food and urine stains on it. The client's apartment and person have a strong foul odor that can be noticed even from outside his apartment. The landlord has informed you that the client is at risk of eviction, due to the smells in his apartment. The client can ambulate without any assistive devices, but he has a slow gait. If he is not lying in bed, he can usually be found the lobby of the apartment complex, speaking to himself and slowly pacing.

When you meet him, he is pacing in the lobby, slowly muttering to himself. The weather is warm, yet he is wearing a jacket and a sweater. You approach him closely by saying somewhat loudly, "Hello there", trying to get his attention. The client appears startled, telling you "Get away from me". You step back a bit, saying slowly and calmly that you are here to help with IHSS needs. You ask if you can see his apartment. After some rambling about how he is being told that he is worthless which you patiently listen to, the client lets you see the apartment. You notice a strong odor when he opens his door with trash lying everywhere. The client also has a pile of what appears to be dirty laundry in the corner of the room. The client appears to be accepting of having an IHSS Provider, but he does not want anyone trying to bathe him or make him change his clothes. He gets quite angry when talking about this, beginning to ramble about his neighbor who he believes wants to poison him. After a few seconds, you raise your hand up, stating, "Hey, no one's trying to poison you. What you need to concentrate on is getting your place clean." At this point the client is yelling telling you to leave, which you do immediately.

1) What are some mistakes the social worker made? How would you have conducted the interview better?

The original approach was too direct and loud. At the end of the interview, by trying to argue with the client and not being supportive, the talk could not continue. The social worker should have listened more about the problems the client is having with his neighbor, gently refocusing him.

2) Is there any risk to the client hurting himself or someone else?

Yes. The client may be at risk of suicide believing that someone is calling him "worthless". He also has a bad relationship with another resident, which may cause the client to want to act out towards him. Both risks should be explored.

3) What are some of the problems the client is having with ADLs that IHSS can assist with? What is the greatest risk for the client that IHSS can assist with?

The client is not cooking for himself due to a delusion. The client also appears to need help with housekeeping or even a heavy cleaning. He could also use some help with laundry. It appears that the client would not be agreeable to changing into clean clothes at first. However, possibly with a good relationship with an IHSS worker, he may be receptive to changing his clothes. The functional impairment in bathing and dressing should be recorded on the H line. Those services should be recorded in the Total Need column of the grid, and recorded as Refused in the Alternative Resources column until he is willing to accept assistance with these tasks. In this example, the risk of eviction appears to be the most crucial piece that IHSS can help with in providing cleaning services. The case plan would be built in small, incremental steps, adding needed services as the client gains trust and becomes able to accept assistance.

Case Example - Depression

Svetlana is a 75 year old woman whose spouse passed away six months ago. Her spouse had been in a nursing home about a year ago, following a stroke. The client is feeling guilty about the decision to place her husband, thinking that it contributed to his death. Although she is physically functioning well, using no assistive device to walk, she appears impaired in her activities of daily living. She has lost contact with her children, accusing them of not caring about her or visiting her often enough. Her grandson calls you, concerned that she needs help with housekeeping.

When you knock at the client's door at 1:00 in the afternoon, she sticks her head out of the upstairs window, telling you that she was asleep. She tells you to come back later. After making another visit in the neighborhood, you come back to interview the client. The client lets you in, dressed in a ratty and dirty old nightgown. The client walks with a hunch and slow gait. As you approach her kitchen, you notice rotting food all over the kitchen with flies buzzing around it. The client's bathroom has dirt caked in the sink and bathroom with some trash placed in the bathtub. The client reports that she used to walk down the street to pick up groceries when her husband lived with her, but that now she rarely goes. The client appears very thin. You are able to notice that she has very little muscle or fat on her.

When you ask about how she is sleeping, the client says that she sleeps in spurts and usually sleeps in late. She is generally cordial and denies being depressed. However, she says "sometimes I just don't know what there is left for me since my husband passed away". You answer by saying, "Look it's a beautiful day. I bet you would feel a lot better if you did a little cleaning or got rid of some that rotten food in the kitchen". The client answers politely, you know I don't think I need any help, but thanks for coming anyway". You leave with the client taking your card, stating that she will call you if needed.

1) What was a mistake the social worker made? How would you have conducted the interview better?

The major mistake was how the social worker interacted with the client at the end. He was not empathetic with her situation, providing unrealistic expectations for her. Although she denied being depressed, there are many clues to show that she is depressed. The social worker should have heard her out more, asking about depression in a language the client could relate to. It would also be important to do a suicide assessment in this case.

2) What are some of the signs of depression in this example?

The client sleeps late, doesn't seem to change her clothes, does not cook, or shower. She had a recent death and she feels guilty for causing this death. She also appears to not be eating very regularly, causing her to be thin.

3) What are the client's IHSS functional impairments? What is the greatest risk for the client that IHSS can assist with?

The client is unable to clean house, shop, cook, and bathe. Though not mentioned, she is probably also impaired in laundry. She would probably rank a 2 in eating, needing prompting and encouragement to eat food that has been prepared for her. The IHSS worker should be first concerned with the client's weight loss, doing an assessment of how much fresh food the client actually has and when the last time she ate was. This case may require a referral to Adult Protective Services. In addition, the IHSS worker is in a good position to question the client more about her depression and suicide risk.

Case Example -Hoarding

Joan is a 65 year old female who lives alone in a two bedroom apartment. She has never been married and does not have any friends in the area. She has had multiple referrals to Public Health in the past for fire hazards, due to her clutter. During every involvement with Public Health, she has worked with her landlord to clean up just enough so that Public Health is satisfied. However, during the most recent referral to Public Health by a neighbor, the client has not been able to clean up as much. She is suffering from severe asthma and appears to have swelling in her legs, which limits her ambulation. The client's landlord tells you that the client will be evicted if she does not clean up her place, putting her at risk of homelessness.

When you meet with the client, she can barely open her door due to the clutter. You can see that there are piles of boxes and trash, piled almost to the ceiling. The client asks what you are there for. You say that you are from In-Home Supportive Services, and that you are there to help "clear out her trash so she won't be evicted". She becomes angry when you mention this, stating that she can't be evicted and that she does not want you touching her belongings. She says the landlord just wants to get her out so that she can raise the rent, slamming the door before you can say anything further.

1)What was a mistake the social worker made? How would you have conducted the interview better?

By calling the client's belongings "trash", it devalued what she considered to be valuable keepsakes. These things are part of her. It seems that the client would be receptive to cleaning, due to having it done in the past. You might not want to jump in immediately with the cleaning idea. Instead, you should ask non threatening questions like what she likes to do, what her background is. Then, after establishing some trust, you could be assertive but empathetic about the need for cleaning.

Schizophrenia

What is it?
Schizophrenia is a chronic, severe, and disabling brain disease. More than 2 million Americans suffer from the illness in a given year. Although schizophrenia affects men and women with equal frequency, the disorder often appears earlier in men, usually in the late teens or early twenties, than in women, who are generally affected in the twenties to early thirties. People with schizophrenia often suffer terrifying symptoms such as hearing internal voices not heard by others, or believing that other people are reading their minds, controlling their thoughts, or plotting to harm them. These symptoms may leave them fearful and withdrawn.

Characteristic symptoms:
Criterion A (DSMIV TR)

1) Delusions
2) Hallucinations
3) Disorganized Speech
4) Grossly disorganized or catatonic behavior
5) Negative symptoms, i.e., affective flattening

Hints for Assessing:

Questions to assess consumer's experience with internal/external stimuli

1) Do you sometimes see things other people don't see, or hear things other people don't hear?
2) Do you ever feel as though you are being watched of followed?

Family Support Suggestions:

1) Provide education for the family on mental illness.
2) Refer consumer to support and assistance through NAMI: **www.namicalifornia.org**
3) Encourage family to attend Doctor appointments with consumer.

Interventions:

1) Psychiatric Assessment
2) Antipsychotic Medication
3) Individual Psychotherapy
4) Family Education
5) Self-help Groups

Depression

What is it?

Major depression is a serious medical illness affecting nearly 10 million American adults, or approximately 5 percent of the adult population in a given year. Major depression can significantly interfere with an individual's thoughts, behavior, mood, activity, and physical health. If untreated, episodes commonly last anywhere from six months to a year.

Characteristic symptoms:

1) Persistently sad or irritable mood
2) Pronounced changes in sleep, appetite, and energy
3) Difficulty thinking, concentrating, and remembering
4) Physical slowing or agitation
5) Lack of interest in or pleasure from activities that were once enjoyed
6) Feelings of guilt, worthlessness, hopelessness, and emptiness
7) Recurrent thoughts of death or suicide
8) Persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders, and chronic pain

NOTE: When several of these symptoms occur at the same time, last longer than two weeks, and interfere with ordinary functioning, professional treatment is needed.

Hints for Assessing

Questions to ask:

1) Are you had a change in sleeping pattern (sleeping more or less than usual?)
2) Have you noticed a change in your appetite? (Either eating more or less?)
3) Have you had thoughts of suicide?

Family Support Suggestions:

1) Encourage consumer to interact with others to avoid isolation.
2) Encourage proper nutrition and exercise appropriate for consumer's level of functioning.
3) Encourage medication compliance or a medication assessment by a psychiatrist if depression persists.

Interventions:

1) Psychiatric Assessment
2) Antidepressant Medication
3) Individual Psychotherapy
4) Depression/Bereavement Groups

Bi-Polar Disorder

What is it?
Bipolar disorder causes extreme shifts in mood, energy, and functioning, it was formerly known as manic depressive disorder. It affects 2.3 million adult Americans, which is about 1.2 percent of the population. The disorder affects men and women equally. Bipolar disorder is characterized by episodes of mania and depression that can last from days to months. It is not uncommon for those who live with bipolar disorder to have symptoms of both mania and depression called a "mixed" episode. "Rapid Cycling" is described as having 4 or more episodes of illness in a 12 month period.

What are the symptoms of mania?

1) Either elated, happy mood or irritable, angry,
2) Increased activity or energy decreased sleep/decreased need for sleep
3) More thoughts and faster thinking than normal
4) Increased talking, more rapid speech
5) Ambitious, often grandiose, plans
6) Increased sexual interest and activity or excessive spending

Hints for Assessing

Questions to ask:

1) Is consumer experiences mood swings between mania and depression?
2) Is consumer involved in any high risk behaviors, i.e., increased sexual activity, over spending, stealing, substance abuse?
3) Has consumer attempted suicide in the past or has current ideation?

Family Support Suggestions:

1) Encourage consumer to be medication compliant and to keep regular Doctor appointments.
2) Encourage consumer to keep a daily mood chart to track their symptoms

Interventions:

1) Psychiatric Assessment
2) Antidepressant Medication
3) Medication to stabilize mood
4) Individual Psychotherapy
5) Groups designed to assist consumer in managing their illness

IHSS Regulations

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CHAPTER 30-700 SERVICE PROGRAM NO. 7: IN-HOME SUPPORTIVE SERVICES

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30-700 PROGRAM DEFINITION 30-700

.1 The In-Home Supportive Services (IHSS) Program provides assistance to those eligible aged, blind and disabled individuals who are unable to remain safely in their own homes without this assistance. IHSS is an alternative to out-of-home care. Eligibility and services are limited by the availability of funds.

.2 The Personal Care Services Program (PCSP) provides personal care services to eligible Medi-Cal beneficiaries pursuant to Welfare and Institutions Code Section 14132.95 and Title 22, California Code of Regulations, Division 3 and is subject to all other provisions of Medi-Cal statutes and regulations. The program is operated pursuant to Division 30.

.3 Individuals who qualify for both IHSS and PCSP funding shall be funded by PCSP.

.4 All civil rights laws, rules, and regulations of Division 21 shall be complied with in administering IHSS program regulations.

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Section 14132.95, Welfare and Institutions Code.

30-701 SPECIAL DEFINITIONS 30-701

(a) (1) Administrative costs are those costs necessary for the proper and efficient administration of the county IHSS program as defined below. Activities considered administrative in nature include, but are not limited to:

(A) Determine eligibility;

(B) Conduct needs assessments;

(C) Give information and referrals;

(D) Establish case files;

(E) Process Notices of Action;

(F) Arrange for services;

(G) Compute shares of cost;

(H) Monitor and evaluate contractor performance;

(I) Respond to inquiries;

(J) Audit recipient and individual provider timesheets;

30-701 SPECIAL DEFINITIONS (Continued) **30-701**

(K) Enter case and payroll information into the CMIPS;

(L) Screen potential providers and maintain a registry or list.

(2) Administrative activities for PCSP are those activities necessary for the proper and efficient administration of the county PCSP. In addition to all activities listed in Section 30-753(a)(1) as administrative activities for IHSS except Section 30-753(a)(1)(G), the following activities are considered administrative in nature, subject to PCSP funding:

(A) Nursing supervision;

(B) Clerical staff directly supporting nursing supervision of PCSP cases;

(C) Physician certification of medical necessity when such certification is completed by a licensed health care professional who is a county employee;

(D) Provider enrollment certification.

(3) Allocation means federal, state, and county monies which are identified for a county by the Department for the purchase of services in the IHSS Program.

(b) (1) Base Allocation means all federal, state and county monies identified for counties by the Department for the purchase of services in the IHSS Program, exclusive of any provider COLA allocation, but including recipient COLA.

(2) Base Rate means the amount of payment per unit of work before any premium is applied for overtime or related extraordinary payments.

(c) (1) Certified Long-Term Care Insurance Policy or Certificate or certified policy or certificate means any long-term care insurance policy or certificate, or any health care service plan contract covering long-term care services, which is certified by the California Department of Health Services as meeting the requirements of Welfare and Institutions Code Section 22005.

(2) Compensable services are only those services for which a provider could legally be paid under the statutes.

(3) Consumer means an individual who is a current or past user of personal care services, as defined by Section 30-757.14, paid for through public or private funds or a recipient of IHSS or PCSP.

(4) County Plan means the annual plan submitted to the California Department of Social Services specifying how the county will provide IHSS and PCSP.

(5) CRT or Cathode Ray Tube means a device commonly referred to as a terminal which is used to enter data into the IHSS payrolling system.

30-701 SPECIAL DEFINITIONS (Continued) **30-701**

(6) CRT County means a county in which one or more CRTs have been located allowing the county to enter its data directly into the payrolling system.

(d) (1) Deeming means procedures by which the income and resources of certain relatives, living in the same household as the recipient, are determined to be available to the recipient for the purposes of establishing eligibility and share of cost.

(2) Designated county department means the department designated by the county board of supervisors to administer the IHSS program.

(3) Direct advance payment means a payment to be used for the purchase of authorized IHSS which is sent directly to the recipient in advance of the service actually being provided.

(e) (1) Employee means the provider of IHSS under the individual delivery method as defined in Section 30-767.13.

(2) Employer means the recipient of IHSS when such services are purchased under the individual delivery method as defined in Section 30-767.13.

(3) Equity Value means a resource's current market value after subtracting the value of any liens or encumbrances against the resources which are held by someone other than the recipient or his/her spouse.

(f) (Reserved)

(g) Gatekeeper Client means a person eligible for, but not placed in a skilled or intermediate care facility as a result of preadmission screening.

(h) (1) Hours Worked means the time during which the provider is subject to the control of the recipient, and includes all the time the provider is required or permitted to work, exclusive of time spent by the provider traveling to and from work.

(2) Housemate means a person who shares a living unit with a recipient. An able and available spouse or a live-in provider is not considered a housemate.

(i) (1) "Intercounty Transfer" means a transfer of responsibility for the provision of IHSS services from one county to another when the recipient moves to a new county and continues to be eligible for IHSS:

(A) "Transferring County" means the county currently authorizing IHSS services.

(B) "Receiving County" means the county to which the recipient moves to make his/her home.

30-701 SPECIAL DEFINITIONS (Continued) **30-701**

(C) "Transfer Period" means the period during which the transferring county remains responsible for payment of IHSS services, after which the receiving county will be responsible for payment. The transfer period starts when the transferring county sends the documentation, including the notice of transfer form, and records to the receiving county.

(D) "Expiration of Transfer Period" means the end of the transfer period. The transfer period shall end as soon as administratively possible but no later than the first day of the month following 30 calendar days after the notification of transfer form is sent to the receiving county or as allowed in Section 30-759.96.

30-701 SPECIAL DEFINITIONS (Continued) **30-701**

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(E) Example: The transferring county sends a notification of transfer form along with documents to the receiving county on January 20th.

The receiving county has 30 calendar days to return the transfer form. The receiving county returns the transfer form on February 19th, stating that they will assume responsibility effective March 1st.

- The transfer period begins January 20th.

- The transfer period ends on March 1st. IHSS payment is terminated by the transferring county.

- The receiving county begins IHSS payment effective March 1st and the transfer is complete.

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(j) (Reserved)

(k) (Reserved)

(l) (1) Landlord/Tenant Living Arrangement means a shared living arrangement considered to exist when one housemate, the landlord, allows another, the tenant, to share housing facilities in return for a monetary or in-kind payment for the purpose of augmenting the landlord's income. A landlord/tenant arrangement is not considered to exist between a recipient and his/her live-in provider. Where housemates share living quarters for the purpose of sharing mortgage, rental, and other expenses, a landlord tenant relationship does not exist, though one housemate may customarily collect the payment(s) of the other housemate(s) in order to pay mortgage/rental payments in a lump sum.

(2) Licensed Health Care Professional means a person who is a physician as defined and authorized to practice in this state in accordance with the California Business and Professions Code.

(3) Live-In Provider means a provider who is not related to the recipient and who lives in the recipient's home expressly for the purpose of providing IHSS-funded services.

30-701 SPECIAL DEFINITIONS (Continued) **30-701**

(4) A list means any informal or formal listing or registry of written name(s) of prospective In-Home Support Services providers maintained by the county agency, county social services staff, a contractor as defined under Welfare and Institutions Code Section 12302.1, or any public or private agency for purposes of referring the prospective providers for employment.

(m) Minor means any person under the age of eighteen who is not emancipated by marriage or other legal action.

(n) (1) Net Nonexempt Income means income remaining after allowing all applicable income disregards and exemptions.

(2) Nonprofit consortium means an association that has a tax-exempt status and produces a tax exempt status certificate and mees the definition of a nonprofit organization as contained in OMB Circular A-122 found at Federal Register, Vol. 45, No. 132, dated July 8, 1980.

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(A) OMB Circular A-122 found at Federal Register, Vol. 45, No. 132, dated July 8, 1980, defines a nonprofit organization as one which:

(1) Operates in the public interest for scientific, educational, service or charitable purposes;

(2) Is not organized for profit making purposes;

(3) Is not controlled by or affiliated with an entity organized or operated for profit making purposes; and

(4) Uses its net proceeds to maintain, improve or expand its operations.

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(o) (1) Out-of-Home Care Facility means a housing unit other than the recipient's own home, as defined in (o) (2) below. Medical out-of-home care facilities include acute care hospitals, skilled nursing facilities, and intermediate care facilities. Nonmedical out-of-home care facilities include community care facilities and homes of relatives which are exempt from licensure, as specified in Section 46-325.5, where recipients are certified to receive board and care payment level from SSP.

(2) Own Home means the place in which an individual chooses to reside. An individual's "own home" does not include an acute care hospital, skilled nursing facility, intermediate care facility, community care facility, or a board and care facility. A person receiving an SSI/SSP payment for a nonmedical out-of-home living arrangement is not considered to be living in his/her home.

30-701 **SPECIAL DEFINITIONS** (Continued) 30-701

(p) (1) Paper County means a county which sends its data in paper document form for entry into the payrolling system to the IHSS payrolling contractor.

(2) Payment Period means the time period for which wages are paid. There are two payment periods per month corresponding to the first of the month through the fifteenth of the month and the sixteenth of the month through the end of the month.

(3) Payrolling System means a service contracted for by the state with a vendor to calculate paychecks to individual providers of IHSS; to withhold the appropriate employee taxes from the provider's wages; to calculate the employer's taxes; and to prepare and file the appropriate tax return.

(4) Personal Attendant means a provider who is employed by the recipient and, as defined by 29 CFR 552.6, who spends at least eighty percent of his/her time in the recipient's employ performing the following services:

(A) Preparation of meals, as provided in Section 30-757.131.

(B) Meal clean-up, as provided in Section 30-757.132.

(C) Planning of menus, as provided in Section 30-757.133.

(D) Consumption of food, as provided in Section 30-757.14(c).

(E) Routine bed baths, as provided in Section 30-757.14(d).

(F) Bathing, oral hygiene and grooming, as provided in Section 30-757.14(e).

(G) Dressing, as provided in Section 30-757.14(f).

(H) Protective supervision, as provided in Section 30-757.17.

(5) Preadmission Screening means personal assessment of an applicant for placement in a skilled or intermediate care facility, prior to admission to determine the individual's ability to remain in the community with the support of community-based services.

(6) Provider Cost-of-Living Adjustment (COLA) means all federal, state and county monies identified for counties by SDSS for the payment of wage and/or benefit increases for service providers in the IHSS program.

30-701 SPECIAL DEFINITIONS (Continued) **30-701**

(7) Public Authority means:

(A) An entity established by the board of supervisors by ordinance, separate from the county, which has filed the statement required by Section 53051 of the Government Code, and

(B) A corporate public body, exercising public and essential governmental functions and that has all powers necessary and convenient to carry out the delivery of in-home supportive services, including the power to contract for services and make or provide for direct payment to a provider chosen by a recipient for the purchase of services.

(q) (Reserved)

(r) (1) Recipient means a person receiving IHSS, including applicants for IHSS when clearly implied by the context of the regulations.

(2) Reduced payment means any payment less than full payment that may be due.

(s) (1) Severely Impaired Individual means a recipient with a total assessed need, as specified in Section 30-763.5, for 20 hours or more per week of service in one or more of the following areas:

(A) Any personal care service listed in Section 30-757.14.

(B) Preparation of meals.

(C) Meal cleanup when preparation of meals and consumption of food (feeding) are required.

(D) Paramedical services.

(2) Shared Living Arrangement means a situation in which one or more recipients reside in the same living unit with one or more persons. A shared living arrangement does not exist if a recipient is residing only with his/her able and available spouse.

(3) Share of cost means an individual's net non-exempt income in excess of the applicable SSI/SSP benefit level which must be paid toward the cost of IHSS authorized by the county.

(4) Spouse means a member of a married couple or a person considered to be a member of a married couple for SSI/SSP purposes. For purposes of Section 30-756.11 for determining PCSP eligibility, spouse means legally married under the laws of the state of the couple's permanent home at the time they lived together.

30-701 SPECIAL DEFINITIONS (Continued) **30-701**

(5) SSI/SSP means the Supplemental Security Income and State Supplementary Program administered by the Social Security Administration of the United States Department of Health and Human Services in California.

(6) State Allocation Plan means that process whereby individual county IHSS program allocations are developed in a manner consistent with a) Welfare and Institutions Code Sections 10102 and 12300 et seq., and b) funding levels appropriated and any control provision contained in the Annual Budget Act.

(7) State-mandated program cost means those county costs incurred for the provision of IHSS to recipients, as specified in Section 30-757, in compliance with a state approved county plan. Costs caused by factors beyond county control such as caseload growth and increased hours of service based on individually assessed need, shall also be considered state-mandated.

(8) Substantial Gainful Activity means work activity that is considered to be substantial gainful activity under the applicable regulations of the Social Security Administration, 20 CFR 416.932 through 416.934. Substantial work activity involves the performance of significant physical or mental duties, or a combination of both, productive in nature. Gainful work activity is activity for remuneration of profit, or intended for profit, whether or not profit is realized, to the individual performing it or to the persons, if any, for whom it is performed, or of a nature generally performed for remuneration or profit.

(9) Substitute Payee means an individual who acts as an agent for the recipient.

(t) Turnaround Timesheet means a three-part document issued by the state consisting of the paycheck, the statement of earnings, and the timesheet to be submitted for the next pay period.

(u) (Reserved)

(v) (1) Voluntary Services Certification is the form numbered SOC 450 (10/98) which is incorporated by reference and which is to be used statewide by person(s) providing voluntary services without compensation.

(w) (Reserved)

(x) (Reserved)

(y) (Reserved)

(z) (Reserved)

NOTE: Authority cited: Sections 10553, 10554, 12301.1, and 22009(b), Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Sections 10554, 11102, 12300(c), 12301, 12301.6, 12304, 12306, 12308, 13302, 14132.95, 14132.95(e), 14132.95(f), and 22004, Welfare and Institutions Code.

30-755 PERSONS SERVED BY THE NON-PCSP IHSS PROGRAM 30-755

.1 Eligibility

.11 A person is eligible for IHSS who is a California resident living in his/her own home, and who meets one of the following conditions:

.111 Currently receives SSI/SSP benefits.

.112 Meets all SSI/SSP eligibility criteria including income, but does not receive SSI/SSP benefits.

.113 Meets all SSI/SSP eligibility criteria, except for income in excess of SSI/SSP eligibility standards and meets applicable share of cost obligations.

.114 Was once eligible for SSI/SSP benefits, but became ineligible because of engaging in substantial gainful activity, and meets all of the following conditions:

(a) The individual was once determined to be disabled in accordance with Title XVI of the Social Security Act (SSI/SSP).

(b) The individual continues to have the physical or mental impairments which were the basis of the disability determination.

(c) The individual requires assistance in one or more of the areas specified under the definition of "severely impaired individual" in Section 30-753.

(d) The individual meets applicable share of cost obligations.

.12 Otherwise eligible applicants, currently institutionalized, who wish to live in their own homes and who are capable of safely doing so if IHSS is provided, shall upon application receive IHSS based upon a needs assessment.

.121 Service delivery shall commence upon the applicant's return home, except that authorized services as specified in Section 30-757.12 may be used to prepare for the applicant's return home.

.2 Eligibility Determination

.21 Eligibility shall be determined by county social service staff at the time of application, at subsequent 12-month intervals, and when required based on information received about changes in the individual's situation.

.22 Eligibility for current recipients of SSI/SSP shall be determined by verifying receipt of SSI/SSP. This can be done in any of the following ways:

30-755 PERSONS SERVED BY THE NON-PCSP IHSS PROGRAM (Continued) **30-755**

.221 Seeing the current SSI/SSP Notice of Determination.

.222 Seeing the current SSI/SSP benefit check.

.223 Contacting the Social Security District Office.

.224 Checking the Medi-Cal Eligibility Data System (MEDS) or the State Data Exchange (SDX) screens.

.23 Eligibility for those persons described in Sections 30-755.112, .113, and .114 above shall be determined as follows:

.231 Age, blindness, and disability shall be determined by social service staff using the eligibility standards specified in Sections 30-770 through 30-775.

(a) Age, blindness or disability may be established by looking at the third and fourth digits of the Medi-Cal number. If the number is 10, the recipient is aged; if 20, the recipient is blind; and if 50, the recipient is disabled. However, if the third and fourth digits of the number are not 20 or 50, a new determination of blindness or disability may be required.

.232 Residence, property, and net nonexempt income shall be determined by social service staff using the eligibility standards specified in Sections 30-770 through 30-775.

.233 Net nonexempt income in excess of the applicable SSI/SSP benefit level shall be applied to the cost of IHSS.

(a) Payment of the entire obligated share of cost is a condition of eligibility for IHSS.

(b) Providers shall have the primary responsibility for collecting any share of cost owed to them.

(1) The county may collect the share of cost.

(2) Counties shall have the responsibility for collection of any share of cost which must be paid against the provider's tax liability.

(3) If a recipient fails to pay his/her entire obligated share of cost within the month for which it is obligated, IHSS shall be terminated.

30-755 PERSONS SERVED BY THE NON-PCSP IHSS PROGRAM (Continued) **30-755**

(1) Termination will be effective the last day of the month following the month of discovery of the recipient's failure to pay his/her entire obligated share of cost.

(d) If an applicant/recipient states verbally or in writing that he/she will not pay his/her share of cost, the applicant/recipient shall not be eligible for IHSS services.

.24 Notwithstanding Section 30-755.232 above, net nonexempt income for persons specified in Section 30-755.113 above shall be determined, depending on the aid category to which the individual was linked in December, 1973, according to the Old Age Security (OAS), Aid to the Blind (AB) and Aid to the Totally Disabled (ATD) income regulations which would have been applicable in the individual's case in June, 1973, if it is to the person's advantage and either of the following conditions is met:

.241 In December 1973 the person was receiving only homemaker/chore services or was receiving an OAS, AB or ATD cash grant solely for attendant care, and has received IHSS services continuously since that date.

.242 In December 1973 the person had applied for attendant care of homemaker/chore service, met all eligibility requirements in that month, and has received IHSS services continuously since that date.

.25 The case record for persons specified in .111 above shall indicate the information used to determine receipt of SSI/SSP benefits.

.26 The case record for persons specified in Sections 30-755.112, .113, and .114 above shall include:

.261 The information used by the county to determine age, blindness or disability.

.262 The information regarding the recipient's property, income, and living situation used by the county in determining eligibility. Such information shall be recorded on a statement of facts form which shall be signed by the recipient or his/her authorized representative under penalty of perjury, and shall be dated. The county shall verify income. The county may verify other information if necessary to insure a correct eligibility determination.

30-755 PERSONS SERVED BY THE NON-PCSP IHSS PROGRAM (Continued) **30-755**

.263 For persons eligible under .114 above, the information used to decide that the recipient was once determined to be eligible for SSI/SSP, was once determined to be disabled as provided in .114(a) above, and was discontinued from SSI/SSP because of engaging in substantial gainful activity.

.264 The computation of the amount the recipient must pay toward the cost of in-home supportive services.

.3 Medi-Cal

.31 Recipients of services under .112, .113, and .114 above are eligible for Medi-Cal, provided that any net nonexempt income in excess of the SSI/SSP benefit level shall be applied to the cost of in-home supportive services.

NOTE: Authority cited: Sections 10553, 10554, and 12150, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Sections 10554, 12304.5, 12305, and 14132.95, Welfare and Institutions Code.

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30-756 NEED **30-756**

.1 Staff of the designated county department shall determine the recipient's level of ability and dependence upon verbal or physical assistance by another for each of the functions listed in Section 30-756.2. This assessment shall evaluate the effect of the recipient's physical, cognitive and emotional impairment on functioning. Staff shall quantify the recipient's level of functioning using the following hierarchical five-point scale:

.11 Rank 1: Independent: able to perform function without human assistance, although the recipient may have difficulty in performing the function, but the completion of the function, with or without a device or mobility aid, poses no substantial risk to his or her safety. A recipient who ranks a "1" in any function shall not be authorized the correlated service activity.

.12 Rank 2: Able to perform a function, but needs verbal assistance, such as reminding, guidance, or encouragement.

.13 Rank 3: Can perform the function with some human assistance, including, but not limited to, direct physical assistance from a provider.

.14 Rank 4: Can perform a function but only with substantial human assistance.

.15 Rank 5: Cannot perform the function, with or without human assistance.

.2 Staff of the designated county department shall rank the recipient's functioning in each of the following functions.

(a) Housework;

(b) Laundry;

(c) Shopping and errands;

(d) Meal preparation and cleanup;

(e) Mobility inside;

30-756 NEED (Continued) **30-756**

(f) Bathing and grooming;

(g) Dressing;

(h) Bowel, bladder and menstrual;

(i) Repositioning;

(j) Eating;

(k) Respiration;

(l) Memory;

(m) Orientation; and

(n) Judgment.

.3 Staff of the designated county department shall use the following criteria to support the determination of functional impairment:

.31 The recipient's diagnosis may provide information to substantiate demonstrated functional impairments, but the recipient's functioning is an evaluation of the recipient's capacity to perform self-care and daily chores.

.32 Need may be distinct from current practice. The assessment of need shall identify the recipient's capacity to perform functions safely. The assessment of need shall identify the recipient's capacity rather than level of dependence.

.33 The recipient's needs shall be assessed within his/her environment, considering the mechanical aids or durable medical appliances the recipient uses.

.34 The scales are hierarchical. The higher the score, the more dependent the recipient is upon another person to perform IHSS services activities.

.35 Most functions are evaluated on a five-point scale. However, the functions of memory, orientation and judgment contain only three ranks. The function of respiration contains only ranks 1 and 5. These inconsistencies in the ranking patterns exist because differing functional ability in these areas does not result in significantly different need for human assistance.

30-756 **NEED** (Continued) 30-756

.36 The order in which the physical functions are listed in Sections 30-756.2(a) through (k) is hierarchical.

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.361 In 95 percent of any impaired population, people tend to lose functioning in the inverse order of normal infant development. Therefore, it would be unlikely for a recipient to score higher ranks in the functions listed at the bottom of the list than those at the top. This listing should assist in the assessment process.

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.37 Mental functioning shall be evaluated as follows:

.371 The extent to which the recipient's cognitive and emotional impairment (if any) impacts his/her functioning in the 11 physical functions listed in Sections 30-756.2(a) through (k) is ranked in each of those functions. The level and type of human intervention needed shall be reflected in the rank for each function.

.372 The recipient's mental function shall be evaluated on a three-point scale (Ranks 1, 2, and 5) in the functions of memory, orientation and judgment. This scale is used to determine the need for protective supervision.

.4 Notwithstanding Section 30-756.11, staff shall rank a recipient the rank of "1" if the recipient's needs for a particular function are met entirely with paramedical services as described in Section 30-757.19 in lieu of the correlated task.

.41 If all of the recipient's ingestion of nutrients occurs with tube feeding, the recipient shall be ranked "1" in both meal preparation and eating because tube feeding is a paramedical service.

.42 If all the recipient's needs for human assistance in respiration are met with the paramedical services of tracheostomy care and suctioning, the recipient should be ranked a "1" because this care is paramedical service rather than respiration.

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Section 12309, Welfare and Institutions Code; and the State Plan Amendment, approved pursuant to Section 14132.95(b), Welfare and Institutions Code.

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30-757 PROGRAM CONTENT 30-757

.1 Only those services specified below shall be authorized through IHSS. A person who is eligible for a personal care service provided pursuant to the PCSP shall not be eligible for that personal care service through IHSS. A service provided by IHSS shall be equal to the level of the same service provided by PCSP.

.11 Domestic services which are limited to the following:

(a) Sweeping, vacuuming, washing and waxing of floor surfaces.
(b) Washing kitchen counters and sinks.
(c) Cleaning the bathroom.
(d) Storing food and supplies.
(e) Taking out garbage.
(f) Dusting and picking up.
(g) Cleaning oven and stove.
(h) Cleaning and defrosting refrigerator.
(i) Bringing in fuel for heating or cooking purposes from a fuel bin in the yard.
(j) Changing bed linen.
(k) Miscellaneous domestic services (e.g., changing light bulbs) when the service is identified and documented by the caseworker as necessary for the recipient to remain safely in his/her home.

.12 Heavy cleaning which involves thorough cleaning of the home to remove hazardous debris or dirt.

.121 The county shall have the authority to authorize this service only at the time IHSS is initially granted, to enable the provider to perform continuous maintenance; or if a lapse in eligibility occurs, eligibility is reestablished, and IHSS has not been provided within the previous 12 months. The county shall also have the authority to authorize this service should the recipient's living conditions result in a threat to his/her safety and such service may be authorized where a recipient is at risk of eviction for failure to prepare his/her home or abode for fumigation as required by statute or ordinance. The caseworker shall document the circumstances, justifying any such allowance.

.13 Related services limited to:

.131 Preparation of meals, includes such tasks as washing vegetables, trimming meat, cooking, setting the table, serving the meals, and cutting the food into bite-size pieces.

.132 Meal clean-up, including washing and drying dishes, pots, utensils, and culinary appliances, and putting them away.

.133 Planning of menus.

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30-757 PROGRAM CONTENT (Continued) **30-757**

.134 Restaurant meal allowance.

(a) An aged or disabled client who has adequate cooking facilities at home but whose disabilities prevent their use shall be advised of his/her option to receive a restaurant meal allowance in lieu of the services specified in .131 through .133, above, and shopping for food which the recipient would otherwise receive.

(1) The amount of the restaurant meal allowance shall be that specified in Welfare and Institutions Code Section 12303.7 or as otherwise provided by law.

(A) IHSS restaurant meal allowances established in accordance with Welfare and Institutions Code Section 12303.7 shall be as follows:

Allowance for an Individual	Allowance for a Couple
$62.00 per month	$124.00 per month

(2) A recipient who receives a restaurant meal allowance as part of his/her SSP grant shall not receive a restaurant meal allowance from IHSS.

(3) An aged or disabled recipient who is an SSP recipient, who requests a restaurant meal allowance, and who does not have adequate cooking facilities at home shall be referred to SSP.

30-757 PROGRAM CONTENT (Continued) **30-757**

.135 Laundry services including the tasks of washing and drying laundry, mending, ironing, folding, and storing clothes on shelves or in drawers.

(a) Laundry facilities are considered available in the home if, at a minimum, there exists a washing machine and a capability to dry clothes on the premises.

(b) The need for out-of-home laundry services exists when laundry facilities are not available on the premises and it is therefore necessary to go outside the premises to accomplish this service. Included in out-of-home laundry is the time needed to travel to/from a locally available laundromat or other laundry facility.

.136 Reasonable food shopping and other shopping/errands limited to the nearest available stores or other facilities consistent with the client's economy and needs.

(a) The county shall not authorize additional time for the recipient to accompany the provider.

(b) Food shopping includes the tasks of making a grocery list, travel to/from the store, shopping, loading, unloading, and storing food.

(c) Other shopping/errands includes the tasks of making a shopping list, travel to/from the store, shopping, loading, unloading, and storing supplies purchased, and/or performing reasonable errands such as delivering a delinquent payment to avert an imminent utility shut-off or picking up a prescription, etc.

.14 Personal care services, limited to:

(a) Bowel and bladder care, such as assistance with enemas, emptying of catheter or ostomy bags, assistance with bed pans, application of diapers, changing rubber sheets and assistance with getting on and off commode or toilet.

(b) Respiration limited to nonmedical services such as assistance with self-administration of oxygen and cleaning IPPB machines.

(c) Consumption of food and assurance of adequate fluid intake consisting of feeding or related assistance to recipients who cannot feed themselves or who require assistance with special devices in order to feed themselves or to drink adequate liquids.

30-757 **PROGRAM CONTENT** (Continued) 30-757

(d) Routine bed baths.

(e) Bathing, oral hygiene and grooming.

(f) Dressing.

(g) Rubbing of skin to promote circulation, turning in bed and other types of repositioning, assistance on and off seats and wheelchairs, or into and out of vehicles, and range of motion exercises which shall be limited to the following:

(1) General supervision of exercises which have been taught to the recipient by a licensed therapist or other health care professional to restore mobility restricted because of injury, disuse or disease.

(2) Maintenance therapy when the specialized knowledge and judgment of a qualified therapist is not required and the exercises are consistent with the patient's capacity and tolerance.

(A) Such exercises shall include the carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function, improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities; and assistive walking.

(h) Moving into and out of bed.

(i) Care of and assistance with prosthetic devices and assistance with self-administration of medications.

(1) Assistance with self-administration of medications consists of reminding the recipient to take prescribed and/or over-the-counter medications when they are to be taken and setting up Medi-sets.

(j) Routine menstrual care, limited to application of sanitary napkins and external cleaning.

(k) Ambulation, consisting of assisting the recipient with walking or moving the recipient from place to place.

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30-757 PROGRAM CONTENT (Continued) **30-757**

.15 Assistance by the provider is available for transportation when the recipient's presence is required at the destination and such assistance is necessary to accomplish the travel, limited to:

.151 Transportation to and from appointments with physicians, dentists and other health practitioners.

.152 Transportation necessary for fitting health related appliances/devices and special clothing.

.153 Transportation under .151 and .152 above shall be authorized only after social service staff have determined that Medi-Cal will not provide transportation in the specific case.

.154 Transportation to the site where alternative resources provide in-home supportive services to the recipient in lieu of IHSS.

.16 Yard hazard abatement is light work in the yard which may be authorized for:

.161 Removal of high grass or weeds, and rubbish when this constitutes a fire hazard.

.162 Removal of ice, snow or other hazardous substances from entrances and essential walkways when access to the home is hazardous.

.163 Such services are limited by Sections 30.763.235(b) and .24.

.17 Protective supervision consisting of observing recipient behavior in order to safeguard the recipient against injury, hazard, or accident.

30-757 **PROGRAM CONTENT** (Continued) 30-757

.171 This service is available for monitoring the behavior of nonself-directing, confused, mentally impaired, or mentally ill persons, with the following exceptions:

(a) Protective supervision does not include friendly visiting or other social activities.

(b) Supervision is not available when the need is caused by a medical condition and the form of the supervision required is medical.

(c) Supervision is not available in anticipation of a medical emergency.

(d) Supervision is not available to prevent or control anti-social or aggressive recipient behavior.

.172 Protective supervision is available under the following conditions:

(a) Social service staff have determined that a twenty-four-hour need exists for protective supervision and that the recipient can remain at home safely if protective supervision is provided.

(b) Services staff determine that the entire twenty-four-hour need for protective supervision can be met through any of the following, or combination of the following:

(1) IHSS

(2) Alternative resources.

(3) A reassurance phone service when feasible and appropriate.

.173 Services staff shall discuss with the recipient, or the recipient's guardian or conservator, the appropriateness of out-of-home care as an alternative to protective supervision.

.174 (Reserved)

.175 (Reserved)

30-757 **PROGRAM CONTENT** (Continued) 30-757

.176 County Social Services staff shall obtain a signed statement from the provider(s) of record or any other person(s) who agrees to provide any In-Home Supportive Services (IHSS) or PCSP compensable service voluntarily. The statement [Form SOC 450 (10/98)] shall indicate that the provider knows of the right to compensated services, but voluntarily chooses not to accept any payment, or reduced payment, for the provision of services.

(a) The voluntary services certification for IHSS shall contain the following information:

(1) Services to be performed;

(2) Recipient(s) name;

(3) Case number;

(4) Day(s) and/or hours per month service(s) will be performed;

(5) Provider of services;

(6) Provider's address and telephone number;

(7) Provider's signature and date signed;

(8) Name and signature of Social Service Worker;

(9) County; and

(10) Social Security Number (Optional, for identification purposes only [Authority: Welfare and Institutions Code Section 12302.2]).

.18 Teaching and demonstration services provided by IHSS providers to enable recipients to perform for themselves services which they currently receive from IHSS. Teaching and demonstration services are limited to instruction in those tasks specified in .11, .13, .14, and .16 above.

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30-757 PROGRAM CONTENT (Continued) **30-757**

.181 This service shall be provided by persons who ordinarily provide IHSS. The hourly rate of provider compensation shall be the same as that paid to other IHSS providers in the county for the delivery method used.

.182 This service shall only be provided when the provider has the necessary skills to do so effectively and safely.

.183 Services shall be authorized for no more than three months.

.184 Services shall be authorized only when there is a reasonable expectation that there will be a reduction in the need for a specified IHSS funded service as a result of the service authorized under this category which is at least equivalent to the cost of the services provided under this category.

(a) The reduction in cost is equivalent if the full cost of service authorized under this part is recovered within six months after the conclusion of the training period.

.185 Within seven months after completion of teaching and demonstration in a specific case, social service staff shall report in to the Department on the results of the service. The report shall include:

(a) The tasks taught.

(b) The instructional method used.

(c) The delivery method used.

(d) The frequency and duration of the instruction.

(e) The total need for each service to be affected both before and six months after the instruction.

(f) The results of instruction including the number of hours of each authorized IHSS funded service to be affected by the instruction both before and six months after the end of the instruction in hours per month.

(g) The hourly rate paid the provider.

30-757 **PROGRAM CONTENT** (Continued) 30-757

.19 Paramedical services, under the following conditions:

.191 The services shall have the following characteristics:

(a) are activities which persons would normally perform for themselves but for their functional limitations,

(b) are activities which, due to the recipient's physical or mental condition, are necessary to maintain the recipient's health.

(c) are activities which include the administration of medications, puncturing the skin, or inserting a medical device into a body orifice, activities requiring sterile procedures, or other activities requiring judgment based on training given by a licensed health care professional.

.192 The services shall be provided when ordered by a licensed health care professional who is lawfully authorized to do so. The licensed health care professional shall be selected by the recipient. The recipient may select a licensed health care professional who is not a Medi-Cal provider, but in that event shall be responsible for any fee payments required by the professional.

.193 The services shall be provided under the direction of the licensed health care professional.

.194 The licensed health care professional shall indicate to social services staff the time necessary to perform the ordered services.

.195 This service shall be provided by persons who ordinarily provide IHSS. The hourly rate of provider compensation shall be the same as that paid to other IHSS providers in the county for the delivery method used.

.196 The county shall have received a signed and dated order for the paramedical services from a licensed health care professional. The order shall include a statement of informed consent saying that the recipient has been informed of the potential risks arising from receipt of such services. The statement of informed consent shall be signed and dated by the recipient, or his/her guardian or conservator. The order and consent shall be on a form developed or approved by the department.

30-757 PROGRAM CONTENT (Continued) **30-757**

.197 In the event that social services staff are unable to complete the above procedures necessary to authorize paramedical services during the same time period as that necessary to authorize the services described in .11 through .18, social services staff shall issue a notice of action and authorize those needed services which are described in .11 through .18 in a timely manner as provided in Section 30-759. Paramedical services shall be authorized at the earliest possible subsequent date.

.198 In no event shall paramedical services be authorized prior to receipt by social services staff of the order for such services by the licensed health care professional. However, the cost of paramedical services received may be reimbursed retroactively provided that they are consistent with the subsequent authorization and were received on or after the date of application for the paramedical services.

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Peremptory Writ of Mandate, Disabled Rights Union v. Woods, Superior Court, Los Angeles County, Case #C 380047; Miller v. Woods/Community Services for the Disabled v. Woods, Superior Court, San Diego County, Case Numbers 468192 and 472068; and Sections 12300, 12300(c)(7), 12300(f), 12300(g), and 12300.1, Welfare and Institutions Code.

30-758 TIME PER TASK AND FREQUENCY GUIDELINES **30-758**

.1 When assessing the need for the services specified in .11 through .15 below in accordance with the provisions of Section 30-763.2, the assessed time shall not exceed the guidelines listed except as provided in .4 below.

.11 Domestic services - The guideline time for "domestic services" shall not exceed 6.0 hours total per month per household.

HANDBOOK BEGINS HERE

.111 Tasks included in domestic services are identified in Section 30-757.11.

HANDBOOK ENDS HERE

.12 Laundry -

.121 For laundry services where laundry facilities are available in the home, the guideline time shall not exceed 1.0 hours total per week per household.

30-758 TIME PER TASK AND FREQUENCY GUIDELINES (Continued) **30-758**

HANDBOOK BEGINS HERE

(a) In-home laundry service is defined and limited in Section 30-757.135.

(b) In assessing time for in-home laundry services, it is expected that the provider will accomplish other tasks while clothes are washing and drying.

HANDBOOK ENDS HERE

.122 For laundry services where laundry facilities are not available in the home, the guideline time shall not exceed 1.5 hours total per week per household.

HANDBOOK BEGINS HERE

(a) Out-of-home laundry service is defined and limited in Section 30-757.135.

(b) It is expected that the typical provider will use a local laundromat during nonpeak hour time and will utilize as many machines simultaneously as necessary for efficient time utilization.

HANDBOOK ENDS HERE

.13 Food Shopping - The guideline time for "food shopping" shall not exceed 1.0 hour total per week per household.

HANDBOOK BEGINS HERE

.131 Food shopping is defined and limited in Section 30-757.136.

HANDBOOK ENDS HERE

.14 Other shopping errands - The guideline time for "other shopping/errands" shall not exceed 0.5 hours total per week per household.

30-758 TIME PER TASK AND FREQUENCY GUIDELINES (Continued) **30-758**

HANDBOOK BEGINS HERE

.141 Other shopping/errands is defined and limited in Section 30-757.136.

HANDBOOK ENDS HERE

.2 Counties shall have the authority to develop and use time per task and frequency guidelines for other services, except:

.21 personal care services, Section 30-757.14.

.22 meal preparation, Section 30-757.131.

.23 meal clean-up, Section 30-757.132.

.24 paramedical services, Section 30-757.19.

.3 No exceptions to time per task guidelines shall be made due to inefficiency or incompetence of the provider.

.4 Welfare and Institutions Code Section 12301.2 states: Time per task guidelines can be used only if appropriate in meeting the individual's particular circumstances. Exceptions to time per task guidelines shall be made when necessary to enable the recipient to establish and maintain an independent living arrangement and/or remain safely in his/her home or abode of his/her own choosing.

.41 When an exception to a time per task guideline is made in an individual case, the reason for the exception shall be documented in the case file.

30-758 TIME PER TASK AND FREQUENCY GUIDELINES (Continued) **30-758**

HANDBOOK BEGINS HERE

.411 Documentation of the reason for the exception will provide necessary data to audit the effectiveness of each guideline in terms of:

(a) achieving equity in assessments; and

(b) evaluating program costs.

HANDBOOK ENDS HERE

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Peremptory Writ of Mandate, Disabled Rights Union v. Woods, Superior Court, Los Angeles County, Case #C 380047; and Section 12300, Welfare and Institutions Code.

30-759 APPLICATION PROCESS **30-759**

.1 Each request or application for services shall have been made in accordance with Section 30-009.22.

.11 Recipient information including ethnicity and primary language (including sign language) shall be collected and recorded in the case file.

.2 Applications shall be processed, including eligibility determination and needs assessment, and notice of action mailed no later than 30 days following the date the written application is completed. An exception may be made for this requirement when a disability determination in accordance with Section 30-771 has not been received in the 30-day period. Services shall be provided, or arrangements for their provision shall have been made, within 15 days after an approval notice of action is mailed.

.3 Pending final determination, a person may be considered blind or disabled for purposes of non-PCSP IHSS eligibility under the following conditions:

.31 For a disabled applicant, eligibility may be presumed if the applicant is not employed and has no expectation of employment within the next 45 days, and if in the county's judgment the person appears to have a mental or physical impairment that will last for at least one year or end in death.

.32 For a blind applicant, eligibility may be presumed if in the county's judgment the person appears to meet the requirements of Section 30-771.2.

30-759 APPLICATION PROCESS (Continued) **30-759**

.4 In-Home Supportive Services payment shall be made for authorizable services, as specified in Section 30-761.28, received on or after the date of application or of the request for services as provided in Section 30-009.224, if either the recipient or the provider does not qualify for PCSP. If the ineligible recipient/provider becomes eligible for payment under PCSP, payment shall be made from PCSP as soon as administratively feasible in lieu of IHSS.

.5 Once services have been authorized, the authorization shall continue until there is a change in eligibility or assessed level of need.

.6 The availability or continuity of services to a recipient shall not be limited or reduced because the county fails to comply with administrative processing standards in this section and in Section 30-761.2, unless the recipient has substantially contributed to the county's failure to comply.

.7 A written notice of action containing information on the disposition of the request for service shall be sent to the applicant in accordance with MPP Sections 10-116 and 30-763.8.

.8 Emergency services may be authorized to aged, blind, or disabled persons prior to the completion of a needs assessment if the recipient meets the eligibility criteria specified in .3 above or in Section 30-755 and the recipient's needs warrant immediate provision of service. The county shall subsequently perform a complete needs assessment within 30 days after the date of application as specified in .4 above, and comply with the standards for application processing.

.9 An intercounty transfer shall be initiated by the transferring county after receiving notification from the recipient or person as described in Section 30-760.1 of his/her move to a new county. This transfer shall be accomplished in accordance with the following procedures:

.91 The transferring county shall, within ten calendar days from the original date of notification, send (by mail or FAX) a notification of transfer form which includes a place for the names and numbers and telephones numbers of the social service workers from both the sending and receiving counties, the statement "Please sign and return a copy of this document which will verify that your county will accept responsibility for the case effective (date to be filled in)," a space for additional comments, and other documents pertaining to the transfer of responsibility and provision of IHSS to the receiving county. If faxed, mailed copy(ies) shall follow in a timely manner for auditing purposes.

.911 The documents required in Section 30-759.91 include, but are not limited to, an application for In-Home Supportive Services (SOC 295, 10/90); the most recent IHSS assessment, an IHSS provider eligibility update, a personal care services program provider enrollment form (SOC 428, 5/90), if applicable; a paramedical authorization form (SOC 321, 10/88), if applicable; current NOAs, and any information pertaining to overpayments and fraud investigations, if applicable.

.92 There shall be no interruption or overlapping of services as the result of a recipient moving from one county to another.

30-759 APPLICATION PROCESS (Continued) **30-759**

.921 The transferring county is responsible for authorizing and funding services until the transfer period expires, at which time the receiving county becomes responsible.

.922 If the recipient moves from the receiving county to a third county during the transfer period, the transferring county is responsible for canceling the transfer to the original receiving county and initiating the transfer to the new receiving county.

.93 The receiving county shall complete and return a notification of transfer form to the transferring county within 30 days of receipt of the form.

.931 If the notification of transfer form has not been returned within 30 calendar days by the receiving county, the transferring county shall contact the receiving county to assure that the new county has received the notification of transfer and is taking action.

.94 As part of the transfer process, the receiving county shall complete a face-to-face assessment with the recipient during the transfer period.

.941 There shall be no change in the recipient's level of authorized hours/benefits taken or initiated by the transferring county during the transfer period unless there is a substantive change in living arrangements or other eligibility factors as verified by the receiving county.

HANDBOOK BEGINS HERE

(a) Some examples of what is considered a "substantive change in living arrangements" follow:

1. A change in the number of persons living in the household;
2. A change in the age(s) of persons living in the household;
3. A change in the layout or location of living areas;
4. A change in the number of rooms in the living space;
5. A change in the availability of cooking facilities;
6. A change in the availability of alternate resources.

(b) The receiving county should be notified immediately once appropriate action, including a notice of action (NOA) is taken.

HANDBOOK ENDS HERE

30-759 APPLICATION PROCESS (Continued) **30-759**

.95 When services are discontinued by the transferring county during the transfer period, and the recipient does not appeal the discontinuance through the state hearing process, any reapplication shall be treated as a new application with the county in which the recipient currently resides (receiving county).

.96 When an IHSS recipient appeals a discontinuance, decrease of hours, or any adverse action against him/her by the transferring county during the transferring process, the transferring county shall maintain full responsibility for the case. The transferring county is accountable for the hearing and aid paid pending (if applicable), until a hearing decision is made, after which the transfer of the case to the receiving county can be completed.

.97 If a person has an IHSS application pending at the time he/she moves to a new county, the responsibility for completion of the application shall remain with the transferring county in accordance with the following:

.971 If the person is eligible at the time the county of residence changes, a transfer process can be initiated.

.972 If a Determination of Disability is pending, responsibility shall be retained by the transferring county until the disability determination is received. The transferring county shall forward the disability determination, along with a notification of transfer form (see Section 30-759.91), within 10 calendar days of the date the determination was received.

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Sections 10950, 11102, 12301, and 14132.95, Welfare and Institutions Code.

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30-760 RESPONSIBILITIES 30-760

.1 Applicant/Recipient Responsibilities

The applicant/recipient, his/her conservator, or in the case of a minor, his/her parents or guardian shall be responsible for:

.11 Completing or participating in completion of all documents required in the determination of eligibility and need for services.

.12 Making available to the county all documents that are in his/her possession or available to him/her which are needed to determine eligibility and need for service.

.13 Reporting all known facts which are material to his/her eligibility and level of need.

.14 Reporting within ten calendar days of the occurrence, any change in any of these facts.

.15 Reporting all information necessary to assure timely and accurate payment to providers of service.

.16 Reporting within 10 calendar days when a change of residence places the recipient within the jurisdiction of another county.

.2 County Responsibilities

.21 Informing recipients of their rights and responsibilities in relation to eligibility and need for services.

.22 Evaluating the capacity of applicants or recipients to discharge their responsibilities as set forth in .1 above.

.23 Assisting recipients as needed in establishing their eligibility and need for service.

.24 Correctly determining eligibility and need.

.25 Complying with administrative standards to insure timely processing of recipient requests for service.

NOTE: Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Sections 11102, 12301, and 14132.95, Welfare and Institutions Code.

30-761 NEEDS ASSESSMENT STANDARDS 30-761

.1 Services shall be authorized only in cases which meet the following condition:

.11 The recipient is eligible as specified in Sections 30-755 or 30-780, except that services may be authorized on an interim basis as provided in Section 30-759.3.

.12 A needs assessment establishes a need for the services identified in Section 30-757 consistent with the purposes of the IHSS program, as specified in Section 30-750, except as provided in Section 30-759.8.

.13 Social services staff of the designated county department has had a face-to-face contact with the recipient in the recipient's home at least once within the past 12 months, and has determined that the recipient would not be able to remain safely in his/her own home without IHSS. If the face-to-face contact is due but the recipient is absent from the state but still eligible to receive IHSS pursuant to the requirements stated in Section 30-770.4, Residency, the face- to-face requirement is suspended until such time as the recipient returns to the state.

.14 Performance of the service by the recipient would constitute such a threat to his/her health/safety that he/she would be unable to remain in his/her own home.

30-761 NEEDS ASSESSMENT STANDARDS (Continued) **30-761**

.2 Needs Assessments

.21 Needs assessments are performed:

.211 Prior to the authorization of IHSS services when an applicant is determined to be eligible, except in emergencies as provided in Section 30-759.8.

.212 Prior to the end of the twelfth calendar month from the last assessment.

(a) If a reassessment is completed before the twelfth calendar month, the month for the next assessment shall be adjusted to the 12-month requirement.

.213 Whenever the county has information indicating that the recipient's physical/mental condition, or living/social situation has changed.

.22 Repealed by Manual Letter No. 82-67 (10/1/82).

.23 The designated county department shall not delegate the responsibility to do needs assessments to any other agency or organization.

.24 The needs assessment shall identify the types and hours of services needed and the services which will be paid for by the IHSS program.

.25 No services shall be determined to be needed which the recipient is able to perform in a safe manner without an unreasonable amount of physical or emotional stress.

30-761 NEEDS ASSESSMENT STANDARDS (Continued) **30-761**

.26 Social service staff shall determine the need for services based on all of the following:

.261 The recipient's physical/mental condition, or living/social situation.

(a) These conditions and situations shall be determined following a face-to-face contact with the recipient, if necessary.

.262 The recipient's statement of need.

.263 The available medical information.

.264 Other information social service staff consider necessary and appropriate to assess the recipient's needs.

.27 A needs assessment and authorization form shall be completed for each case and filed in the case record. The county shall use the needs assessment form developed or approved by the Department. The needs assessment form shall itemize the need for services and shall include the following:

.271 Recipient information including age, sex, living situation, the nature, and extent of the recipient's functional limitations, and whether the recipient is severely impaired.

.272 The types of services to be provided through the IHSS program, the service delivery method and the number of hours per service per week.

.273 Types of IHSS provided without cost or through other resources, including sources and amounts of those services.

.274 Unmet need for IHSS.

.275 Beginning date of service authorization.

30-761 NEEDS ASSESSMENT STANDARDS (Continued) **30-761**

.28 Services authorized shall be justified by and consistent with the most recent needs assessment, but shall be limited by the provisions of Section 30-765.

.3 IHSS staff shall be staff of a designated county department.

.31 Classification of IHSS assessment workers shall be at the discretion of the county.

.32 IHSS assessment workers shall be trained in the uniformity assessment system.

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code. Reference: Section 14132.95, Welfare and Institutions Code; and the State Plan Amendment, approved pursuant to Section 14132.95(b), Welfare and Institutions Code.

30-763 SERVICE AUTHORIZATION **30-763**

.1 Services staff shall determine the need for only those tasks in which the recipient has functional impairments. In the functions specified in Section 30-756.2, a functional impairment shall be a rank of at least 2.

.11 The applicant/recipient shall be required to cooperate to the best of his/her ability in the securing of medical verification which evaluates the following:

.111 His/her present condition.

.112 His/her ability to remain safely in his/her own home without IHSS services.

.113 His/her need for either medical or nonmedical out-of-home care placement if IHSS were not provided.

.114 The level of out-of-home care necessary if IHSS were not provided.

30-763 SERVICE AUTHORIZATION (Continued) **30-763**

.12 Applicant/recipient failure to cooperate as required in Section 30-763.11 shall result in denial or termination of IHSS.

.2 Using the needs assessment form, services staff shall calculate the number of hours per week needed for each of the services determined to be needed by the procedure described in Section 30-763.1.

.3 Shared Living Arrangements: The following steps apply to assessing need for clients who live with another person(s). With certain exceptions specified in Section 30-763.4, the need for IHSS shall be determined in the following manner.

.31 Domestic Services and Heavy Cleaning

.311 The living area in the house shall be divided into areas used solely by the recipient, areas used in common with others, and areas not used by the recipient.

.312 No need shall be assessed for areas not used by the recipient.

.313 The need for services in common living areas shall be prorated to all the housemates, the recipient's need being his/her prorated share.

.314 For areas used solely by the recipient, the assessment shall be based on the recipient's individual need.

.32 Related Services need shall be assessed as follows:

.321 When the need is being met in common with those of other housemates, the need shall be prorated to all the housemates involved, and the recipient's need is his/her prorated share.

30-763 SERVICE AUTHORIZATION (Continued) **30-763**

.322 When the service is not being provided by a housemate, and is being provided separately to the recipient, the assessment shall be based on the recipient's individual need.

.33 The need for protective supervision shall be assessed based on the recipient's individual need provided that:

.331 When two (or more) IHSS recipients are living together and both require protective supervision, the need shall be treated as a common need and prorated accordingly. In the event that proration results in one recipient's assessed need exceeding the payment and hourly maximums provided in Section 30-765, the apportionment of need shall be adjusted between the recipients so that all, or as much as possible of the total common need for protective supervision may be met within the payment and hourly maximums.

.332 For service authorization purposes, no need for protective supervision exists during periods when a provider is in the home to provide other services.

.34 The need for teaching and demonstration services shall be assessed based on the recipient's individual need, except when recipients live together and have a common need, the need shall be met in common when feasible.

.35 Other IHSS Services:

.351 The recipient's need for transportation services, paramedical services and personal care services shall be assessed based on the recipient's individual need.

.352 The need for yard hazard abatement shall not be assessed in shared living arrangements, except when all housemates fall into one or more of the following categories:

(a) Other IHSS recipients unable to provide such services.

(b) Other persons physically or mentally unable to provide such services.

(c) Children under the age of fourteen years.

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30-763 SERVICE AUTHORIZATION (Continued) **30-763**

.4 Exceptions when assessing needs in shared living arrangements:

.41 Able and Available Spouse

.411 When an IHSS recipient has a spouse who does not receive IHSS, the spouse shall be presumed able to perform certain specified tasks unless he/she provides medical verification of his/her inability to do so.

.412 An able spouse of an IHSS recipient shall be presumed available to perform certain specified tasks except during those times he/she is out of the home for employment, health or for other unavoidable reasons and the service must be provided during his/her absence.

.413 When the recipient has an able and available spouse there shall be no payment to the spouse or any other provider for the following services as described in 30-757:

(a) Domestic

(b) Related Services

(c) Yard Hazard Abatement

(d) Teaching and Demonstration

(e) Heavy Cleaning

.414 When an able spouse is not available because of employment, health, or other unavoidable reasons, a provider may be paid for the following services only if they must be provided during the spouse's absence:

(a) Meal Preparation

(b) Transportation

(c) Protective Supervision

.415 An able and available spouse or other provider may be paid for providing:

(a) Personal care services

(b) Paramedical service

30-763 SERVICE AUTHORIZATION (Continued) **30-763**

.416 In addition to those services listed in Section 30-763.445, a spouse may be paid to provide the following services when he/she leaves full-time employment or wishes to seek employment but is prevented from doing so because no other suitable provider is available:

(a) Transportation

(b) Protective Supervision

.42 Landlord/Tenant Arrangements

.421 When the recipient is the tenant, the need for domestic and heavy cleaning services shall be based on the living area used solely by the recipient. No need for yard hazard abatement shall be assessed. The needs assessment shall take into account any services the landlord is obligated to perform under the rental agreement.

.422 When the recipient is the landlord, the need for domestic and heavy cleaning services shall be assessed for all living areas not used solely by the tenant. The needs assessments shall take into account any services the tenant is obligated to perform under the rental agreement.

.43 If the recipient has moved into a relative's home primarily for the purpose of receiving services, the need for domestic and heavy cleaning services shall be assessed only for living areas used solely by the recipient. Yard hazard abatement services shall not be provided.

30-763 SERVICE AUTHORIZATION (Continued) **30-763**

.44 When the recipient is under eighteen years of age and is living with the recipient's parent(s), IHSS may be purchased from a provider other than the parent(s) when no parent is able to provide the services for any of the following reasons:

.441 when the parent(s) is absent because of employment or education or training for vocational purposes.

.442 if the parent(s) is physically or mentally unable to perform the needed services.

.443 when the parent is absent because of on-going medical, dental or other health-related treatment.

.444 up to eight hours per week may be authorized for periods when the parent(s) must be absent from the home in order to perform shopping and errands essential to the family, or for essential purposes related to the care of the recipient's siblings who are minors.

.45 When the recipient is under eighteen years of age and is living with the recipient's parent(s), IHSS may be purchased from a parent under the following conditions:

.451 All of the following conditions shall be met:

(a) The parent has left full-time employment or is prevented from obtaining full-time employment because of the need to provide IHSS to the child;

(b) There is no other suitable provider available;

(c) If the child does not receive the listed services the child may inappropriately require out-of-home placement or may receive inadequate care.

.452 For the purposes of Section 30-763.451(b), a suitable provider is any person, other than the recipient's parent(s), who is willing, available, and qualified to provide the needed IHSS.

30-763 SERVICE AUTHORIZATION (Continued) **30-763**

.453 When both parents are in the home, a parent may receive a payment as an IHSS provider only under the following conditions:

(a) The conditions specified in Sections 30-763.451(a) through (c) shall be met.

(b) The nonprovider parent shall be unable to provide the services because he/she is absent because of employment or in order to secure education as specified in Section 30-763.441, or is physically or mentally unable to provide the services, as specified in Section 30-763.442.

(c) If the nonprovider parent is unable to provide services because he/she is absent for employment or educational purposes, payment shall be made to the provider parent only for services which are normally provided during the periods of the nonprovider parent's absence as indicated above.

.454 The IHSS provided shall be limited to:

(a) Related services, as specified in Section 30-757.13.

(b) Personal care services, as specified in Section 30- 757.14.

(c) Assistance with travel, as specified in Section 30-757.15.

(d) Paramedical services, as specified in Section 30-757.19.

(e) Protective supervision, as specified in Section 30-757.17, limited to that needed because of the functional limitations of the recipient. This service shall not include routine child care or supervision.

.46 When the recipient is a parent living with his/her child(ren) who is under fourteen years of age and who is not eligible or does not need IHSS.

30-763 SERVICE AUTHORIZATION (Continued) **30-763**

.461 The recipient's need for domestic and heavy cleaning services in common living areas, and for related services shall be assessed as if the child(ren) did not live in the home.

.462 The child(ren)'s needs shall not be considered when assessing the need for services, including domestic or heavy cleaning in areas used solely by the child(ren).

.47 Live-in Providers:

.471 Domestic and heavy cleaning services shall not be provided in areas used solely by the provider. The need for related services may be prorated between the provider and the recipient, if the provider and the recipient agree. All other services shall be assessed based on the recipient's individual need, except as provided in Sections 30-763.33 and .34.

.5 Having estimated the need according to Sections 30-763.1 and .2, and after making the adjustments identified in Sections 30-763.3 and .4 as appropriate, the remaining list of services and hours per service is the total need for IHSS services.

.6 Identification of Available Alternative Resources

.61 Social services staff shall explore alternative in-home services supportive services which may be available from other agencies or programs to meet the needs of the recipient as assessed in accordance with Section 30-761.26.

.611 Social services staff shall arrange for the delivery of such alternative resources as necessary in lieu of IHSS program-funded services when they are available and result in no cost to the IHSS program or the recipient except as provided in Section 30-763.613.

30-763 SERVICE AUTHORIZATION (Continued) **30-763**

.612 The IHSS program shall not deliver services which have been made available to the recipient through such alternative resources, except as provided in Section 30-763.613.

.613 In no event shall an alternative resource be used at the financial expense of the recipient, except:

(a) At the recipient's option; or

(b) When the recipient has a share of cost obligation which shall be reduced by the amount necessary for the purchase of the alternative resource.

.62 Social services staff shall explore with the recipient the willingness of relatives, housemates, friends or other appropriate persons to provide voluntarily some or all of the services required by the recipient.

.621 Social services staff shall obtain from the recipient a signed statement authorizing discussion of the case with any persons specified in Section 30-763.62.

.622 Social services staff shall not compel any such volunteer to provide services.

.63 Social services staff shall document on the needs assessment form the total need for a specific service, which shall then be reduced by any service available from an alternative resource. The remaining need for IHSS is the adjusted need.

.64 Social Services staff shall obtain a signed statement from the provider(s) of record or any other person(s) who agrees to provide any IHSS/PCSP compensable service voluntarily. The statement [Form SOC 450 (10/98)] shall indicate that the provider(s) knows of the right to compensated services, but voluntarily chooses not to accept any payment, or reduced payment, for the provision of services. (See MPP Section 30-757.176 for information regarding the voluntary services certification form).

.7 The Determination of Services Which Shall be Purchased by IHSS

.71 Services shall be authorized to meet all of the adjusted need for IHSS up to the appropriate service maximum identified in Section 30- 765.

.72 These services shall not be authorized concurrently with the SSI/SSP nonmedical out-of-home care living arrangement.

.8 Notice of Action

30-763 SERVICE AUTHORIZATION (Continued) **30-763**

.81 Whenever an IHSS needs assessment is completed the recipient shall be sent a notice of action in accordance with the requirements of MPP 10-116 and 30-759.7. In addition to the information required in 10- 116, the notice shall include:

.811 a description of each task for which need is assessed.

.812 the number of hours authorized for the completion of the task.

.813 identification of hours for tasks increased or decreased and the difference from previous hours authorized.

.9 Miller vs. Woods and Community Service Center for the Disabled vs. Woods.

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.91 Background

On October 21, 1983 the Court of Appeal, Fourth Appellate District, issued a decision in the consolidated case of Miller vs. Woods and Community Service Center for the Disabled vs. Woods. The court declared invalid MPP 30-463.233c (now 30-763.233c) which provided that no need for protective supervision may be assessed when a housemate is in the home.

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.92 Case Review Procedures

.921 The county shall identify no later than June 30, 1984 all open IHSS cases with recipients living with a housemate where a need for protective supervision as defined in 30-757.17 may exist.

.922 The county shall determine through recipient contact whether a need for protective supervision exists unless the case record provides conclusive evidence which indicates that no need exists.

.93 Authorization and Notification

.931 The county shall complete a new Needs Assessment form to authorize protective supervision. The authorization shall be effective as of May 1, 1984.

30-763 SERVICE AUTHORIZATION (Continued) **30-763**

.932 The county shall send a Notice of Action to all affected recipients which shall state: "Hours for protective supervision are authorized based on the Miller vs. Woods and Community Service Center for the Disabled vs. Woods court action."

.94 Recordkeeping

.941 The county shall maintain a listing of those recipients who were previously not authorized to receive protective supervision because of the presence of a housemate.

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.942 DSS will provide each county with a computer generated listing which identifies any recipient whose address matches the address of an Individual Provider. The listing should be used as an aid and cross-check in the case review process; the listing is not a substitute for the case review.

.943 For those recipients with an Individual Provider, the listing in Section 30-763.941 will be generated through use of a special reason code indicating increased hours due to the Miller vs. Woods court decision.

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NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Sections 12300, 12309, and 14132.95, Welfare and Institutions Code; and the State Plan Amendment, approved pursuant to Section 14132.95(b), Welfare and Institutions Code; and Miller v. Woods/Community Services for the Disabled v. Woods, Superior Court, San Diego County, Case Numbers 468192 and 472068.

30-764 INDIVIDUAL PROVIDER COMPENSATION 30-764

.1 Computation of Payment

.11 Social service staff shall determine the amount of the IHSS payment required to purchase services to meet the IHSS adjusted need as specified in 763.41 above.

.12 The IHSS payment shall be determined by multiplying the monthly adjusted need for IHSS hours by the base payment rate used by the county, except as provided in .14 below.

.13 The hours and amount of compensation available for personal attendant providers shall be determined by county social services staff. The payment shall be the minimum necessary to obtain adequate service to meet the authorized service needs of the recipient.

.2 Rate of Compensation

.21 The base rate of compensation used by the county shall not be less than the legal minimum wage in effect at the time the work is performed, except when personal attendants are employed.

.22 In advance pay cases, the base rate paid by the recipient to the provider shall not be less than the base rate used by the county for the authorized IHSS payment.

.23 The recipient shall develop a work schedule which is consistent with the authorized service hours at the county's base rate. If the recipient finds that a work schedule cannot be established without requiring payment in excess of the county's base rate, the recipient shall bring such information to the county's attention. The county will determine if payment in excess of the base rate is necessary. Any additional costs resulting from the recipient's actions in work scheduling or increasing the rate paid per work unit shall be borne by the recipient unless prior county approval has been obtained.

.24 No adjustments in the IHSS payment shall be made for meals and lodging provided to the provider by the recipient except as specified in Section 30-763. However, any income received by the recipient through this means is countable income for eligibility purposes as specified in Section 30-775 and shall be reported as such by the recipient.

30-764 INDIVIDUAL PROVIDER COMPENSATION 30-764

.3 Employer Responsibilities

.31 As employers recipients have certain responsibilities for standards of compensation, work scheduling and working conditions as they apply to IHSS individual providers. The county will assure that all recipients understand their basic responsibilities as employers.

.32 Non live-in employees shall be compensated at the base rate for the first forty hours worked during a work week. Each hour, or fraction thereof, worked in excess of forty hours during a work week shall be compensated at one and one-half times the base rate.

30-765 COST LIMITATIONS 30-765

.1 The following limitations shall apply to all payments made for in-home supportive services:

.11 The maximum services authorized per month except as provided in Section 30-765.3, under IHSS to any recipient determined to be severely impaired, as defined in Section 30-753(s)(1) shall be that specified in Welfare and Institutions Code Section 12303.4(b) or as otherwise provided by law.

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.111 The IHSS service hours for a severely impaired recipient receiving services through the individual provider mode of delivery shall not exceed 283 hours per month effective July 8, 1988. (Welfare and Institutions Code Section 12303.4(b)(1)).

.112 Repealed by CDSS Manual Letter No. SS-00-02, effective 4/14/00.

.113 Welfare and Institutions Code Section 12300(g)(2) states:

"Any recipient receiving services under both Section 14132.95 and this article shall receive no more than 283 hours of service per month, combined, and any recipient of services under this article shall receive no more than the applicable maximum specified in Section 12303.4." (See Section 30-765.11.)

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.12 The maximum services authorized per month except as provided in Section 30-765.3, under non-PCSP to any recipient determined not to be severely impaired shall be that specified in Welfare and Institutions Code Section 12303.4(a) or as otherwise provided by law.

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.121 The IHSS service hours for a recipient who is not determined to be severely impaired and receives services through the individual provider mode of service delivery shall not exceed 195 hours per month effective July 8, 1988 (Welfare and Institutions Code Section 12303.4(a)(1)).

.122 Repealed by CDSS Manual Letter No. SS-00-02, effective 4/14/00.

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30-765 COST LIMITATIONS (Continued) **30-765**

.13 The statutory maximum service hours per month shall be inclusive of any payment by IHSS for a restaurant meal allowance established in accordance with the Welfare and Institutions Code Section 12303.7.

.131 The statutory maximum for individuals receiving services through the individual provider mode of service delivery and eligible for the restaurant meal allowance shall be determined by multiplying the statutory maximum hours of service by the county wage rate, subtracting the restaurant meal allowance (see Section 30-757.134(a)(1)(A)) from this product and dividing the remainder by the county hourly wage rate.

.132 Repealed by CDSS Manual Letter No. SS-00-02, effective 4/14/00.

.14 The county shall not make monthly payments of IHSS monies to recipients in excess of the computed maximums in Sections 30-765.11, .12 and .13. The sum of the IHSS monthly payment and the recipient's share of cost, if any, shall not exceed the appropriate maximum.

.2 The statewide wage rate for individual providers shall be determined by the Department. Effective July 8, 1988, the statewide wage rate is $4.25.

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.21 DHS regulation Section 51535.2 reads:

Reimbursement Rates for Personal Care Services Program.

(a) For the individual provider mode for providing personal care services, the reimbursement rate shall be a maximum of $5.50 per hour of service: provided, however, that the reimbursement rate in each county shall not exceed the rate in each county for the individual provider mode of service in the IHSS program pursuant to Article 7 (commencing with Section 12300) of Part 3 of Division 9 of the Welfare and Institutions Code, as it existed on September 28, 1992.

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30-765 COST LIMITATIONS (Continued) **30-765**

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(b) For the contract mode for providing personal care services pursuant to Welfare and Institutions Code Sections 12302 and 12302.1, the reimbursement rates shall be those specified in the contract between the county and the agency contractor not to exceed the following maximum rates for services provided through State fiscal year 1993-1994 as follows:

(1)	Butte	$ 9.65
(2)	Nevada	$10.34
(3)	Riverside	$12.29
(4)	San Diego	$10.49
(5)	San Francisco	$12.28
(6)	San Joaquin	$ 9.50
(7)	San Mateo	$12.65
(8)	Santa Barbara	$11.76
(9)	Santa Clara	$11.11
(10)	Santa Cruz	$13.61
(11)	Stanislaus	$10.51
(12)	Tehama	$11.30
(13)	Ventura	$11.04

(c) Nothing in this section is intended to be a limitation on the rights of providers and beneficiaries or on the duties of the Department of Social Services, pursuant to Welfare and Institutions Code Section 12302.2 subdivision (a). Contributions, premiums and taxes paid pursuant to Welfare and Institutions Code Section 12302.2, subdivision (a) shall be in addition to the hourly rates specified in subdivision (a) of this section.

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30-765 COST LIMITATIONS (Continued) **30-765**

.3 IHSS recipients receiving services through the individual provider mode of delivery shall not receive less service hours per month than he/she received during June 1988, without a reassessment of need. The reassessment shall not result in an automatic reduction in authorized hours, unless the recipient no longer needs the hours.

.4 These regulations shall remain in effect until July 1, 1990, unless a later enacted regulation extends or repeals that date.

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Sections 12300, 12303.4, and 14132.95, Welfare and Institutions Code.

30-766 COUNTY PLANS 30-766

.1 Each county welfare department shall develop and submit a county plan to CDSS no later than 30 days following receipt of its allocation, which specifies the means by which IHSS will be provided in order to meet the objectives and conditions of the program within its allocation.

.11 The plan shall be submitted to CDSS and shall be based upon relevant information, as specified in Welfare and Institutions Code Sections 12301 and 14132.95, including, but not limited to the information specified below:

.111 Projected caseload, hours paid, and costs per month/quarter by mode;

.112 Modes of IHSS and PCSP service delivery the county intends to use;

.113 Estimated program costs for both the IHSS and PCSP programs;

.114 Methods the county will utilize to control non-PCSP program costs to comply with required fiscal limitations; and

.115 Program design intended to meet PCSP requirements.

.12 County plans and amendments shall be effective upon submission.

.13 CDSS shall review each county plan for compliance with Welfare and Institutions Code Sections 12300, et seq. and 14132.95, regulations of CDSS and DHS, and when appropriate, issue departmental approval.

.131 CDSS, when appropriate, shall adjust funding levels contained in the plan, as a condition of approval.

.132 A county plan which includes IHSS administrative costs shall not be issued departmental approval.

.133 If, after review, CDSS determines that a county plan is not in compliance, the Department shall require the county to amend its plan.

.134 CDSS shall develop a county plan for counties which have not submitted plans within the required time frame, based on CDSS' estimate for those counties. Such plans shall be effective upon written notification to the county.

30-766 COUNTY PLANS (Continued) **30-766**

.14 In the event that funds are available for reallocation, special consideration shall be given to those counties which submit their county plans by the due date.

.141 CDSS shall be permitted to reallocate funds from counties which are late based on CDSS's estimate for those counties.

.15 Each county shall monitor its expenditures monthly. Upon discovery by either CDSS or the county that anticipated expenditures will exceed the amount of the county's base allocation, the county shall immediately submit to CDSS for approval an amended plan.

.151 Repealed by CDSS Manual Letter No. SS-90-02, effective 10/4/90.

.152 Repealed by CDSS Manual Letter No. SS-90-02, effective 10/4/90.

.16 Counties shall not reduce authorized services or hours of service to recipients in order to remain within their allocation.

.17 All state-mandated program costs, after the required county contribution, shall be eligible for reimbursement from state social service funds. If appropriated funds are insufficient to reimburse counties for all state-mandated costs, the state shall fully reimburse the counties for all state-mandated program costs, less the required county contribution.

.18 The portion of county expenditures which, after the county contribution, exceeds the allocation, shall not be eligible for reimbursement from state social service funds if such deficit is caused by:

.181 Noncompliance with the requirements of the state-approved county plan or State allocation plan; or

.182 Non-state-mandated costs; or

.183 IHSS administrative costs.

30-766 COUNTY PLANS (Continued) 30-766

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(a) Some examples of situations where reimbursement would not be made are:

(1) A county chooses to give a wage/benefit increase to IHSS providers which is higher than that provided in the Budget Act; or

(2) A county chooses to expand its use of a more expensive service delivery mode beyond the level of caseload and hours growth for each mode that is built into the Budget Act; or

(3) A county chooses to enter into a third party contract at an hourly rate higher than the maximum established for that county; or

(4) A county chooses to shift to a more expensive mode without providing for noncomitant offsetting savings in other areas, and causing a cost overrun.

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NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; Chapter 939, Statutes of 1992. Reference: Sections 10102, 12301, 12302, 12306, 12308, 13002, and 14132.95, Welfare and Institutions Code; and Chapter 93, Statutes of 1989 (Budget Act of 1989).

30-767 SERVICE DELIVERY METHODS 30-767

.1 The county shall arrange for the provision of IHSS through one or more of the methods specified below in accordance with an approved county plan:

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Counties may choose modes of delivery that best meet the needs of their recipient population in their county demographic situation (WIC 12302). However, state reimbursement can be available only within the constraints imposed by the annual budget act (WIC 12300) and state allocation plan (WIC 10102), all of which must be reflected in state-approved individual county plans. Counties which exceed the constraints run the risk of not receiving full reimbursement if the cost overrun was due to non-state mandated costs, i.e., costs within county control, or more expensive modes used beyond amounts approved in an individual county plan.

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30-767 SERVICE DELIVERY METHODS (Continued) **30-767**

.11 County Employment.

.111 The county shall be permitted to hire service providers in accordance with established county civil service requirements or merit system requirements. The county shall be permitted to consider such providers as temporary employees if approved by the appropriate civil service system.

.112 The county shall insure that each service provider is capable of and is providing the services authorized.

.12 Purchase of Service from an Agency.

.121 The county may contract with an agency to provide service in accordance with the requirements of Division 10 and 23. The contract shall include a provision requiring the contractor to maintain a listing of contract recipients, their authorized hours, service hours provided and the amount paid for those services to the contract agency.

.122 The county shall insure that the contractor guarantees the continuity and reliability of service to recipients, supervision of service providers, that each service provider is capable of and is providing the service authorized and complies with the requirements of Division 21 (Civil Rights).

.123 The county shall insure that preference is given to the selection of providers who are recipients of public assistance or other low-income persons who would qualify for public assistance in the absence of such employment, except in regard to persons recruited by the recipient.

.13 Purchase of Service From An Individual.

.131 The county shall make payment under this delivery method through the payrolling system as described in Section 30-769.

.132 The county shall make a reasonable effort to assist the recipient to obtain a service provider when the recipient is unable to obtain one individually.

30-767 SERVICE DELIVERY METHODS (Continued) **30-767**

.133 The county shall have the right to change from one to another of the three delivery methods outlined above or from payment in advance to payment in arrears when any of the following apply:

(a) It has been determined that a recipient is using his/her payment for other than the purchase of authorized services.

(b) The recipient has failed to submit time sheets, as specified in Section 30-769.737 within 90 days from the date of payment.

(c) The recipient has not provided timely payment to his/her providers.

.2 Counties may elect to contract with a nonprofit consortium or may create a public authority to provide for the delivery of IHSS.

.21 The board of supervisors shall establish a public authority by ordinance.

.211 The public authority shall be separate from the county. Employees of the public authority shall not be considered to be employees of the county for any purpose.

.212 The ordinance shall designate the governing body of the public authority and specify the qualifications of the individual members, the procedures for nomination, selection, appointment, tenure and removal of members, and such other matters as the board of supervisors deems necessary for the operation of the public authority.

(a) The board of supervisors may designate itself as the governing body of the public authority.

(1) If the board of supervisors is the governing body, the ordinance shall require the appointment of an advisory committee of no more than 11 members.

(2) No fewer than 50 percent of the advisory committee shall be consumers as defined in Manual of Policies and Procedures Section 30-753(c)(1).

(b) If the board of supervisors does not designate itself the governing body of the public authority, it shall specify by ordinance the membership of the governing body of the public authority.

30-767 SERVICE DELIVERY METHODS (Continued) **30-767**

(1) No fewer than 50 percent of the members of the governing body shall be consumers as defined in Manual of Policies and Procedures Section 30-753(c)(1).

.213 Before appointing members to the governing body or advisory committee, the board of supervisors shall solicit recommendations from the general public and interested persons and organizations through a fair and open process which includes reasonable written notice and a reasonable time to respond.

(a) The provisions at Section 30-767.213 shall be met by satisfying the requirements governing legislative bodies outlined in Government Code and other state and federal law, including, but not limited to, the Ralph M. Brown Act (Government Code Section 54950 et seq.) and the Americans with Disabilities Act.

.214 Prior to initiating delivery of IHSS through a public authority, the county shall enter an agreement with the public authority specifying the purposes, scope or nature of the agreement, the roles and responsibilities of each party including provisions which ensure compliance with all applicable state and federal labor laws, and compliance with all statutory and regulatory provisions applicable to the delivery of IHSS. This agreement shall also specify the fiscal provisions under which the public authority shall be reimbursed for its performance under the agreement. The county, in exercising its option to establish a public authority, shall not be subject to competitive bidding requirements.

.215 Prior to initiating the delivery of IHSS through a public authority, the county shall submit to the California Department of Social Services a copy of the agreement as specified in Section 30-767.214 along with the following information concerning the public authority:

(a) Organization chart of the public authority.

(b) Funding provision for public authority costs, including how the proposed rate was developed.

(1) The rate development process and the public authority hourly rate must be approved by Department of Health Services prior to initiating the delivery of services.

(c) Public authority staffing classifications and duties.

(d) A description of how the functional requirements of Welfare and Institutions Code Section 12301.6(e) will be met.

30-767 SERVICE DELIVERY METHODS (Continued) 30-767

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(e) The requirements of Welfare and Institutions Code Section 12301.6(e) are listed in Section 30-767.23.

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.216 If the public authority contracts with another entity to provide the delivery of IHSS, the agreement shall satisfy the requirements of Manual of Policies and Procedures Chapter 23-600 relating to contracting.

.217 All costs claimed for the delivery of services under an agreement as specified in Section 30-767.214 shall be claimed in compliance with criteria for rate setting found at Section F, attachment 4.19-B of the California Medicaid State Plan.

(a) A county shall use county-only funds to fund both the county share and the state share of any increase in the cost of the program, including employment taxes, due to any increase in provider wages or benefits negotiated or agreed to by a public authority or nonprofit consortium unless otherwise provided for in the annual budget act or appropriated by statute. No increase in wages or benefits negotiated or agreed to pursuant to this section shall take effect until the Department has obtained the approval of the State Department of Health Services.

.22 A county may contract with a consortium for delivery of services.

.221 A consortium entering a contract under Section 30-767.22 shall have a governing body composed as described in Section 30-767.212(b)(1), or shall have established an advisory committee composed as described in Sections 30-767.212(a)(1) and (2).

.222 Such contracts shall be subject to the provisions of Manual of Policies and Procedures Chapter 23-600.

.223 A consortium entering a contract under Section 30-767.22 shall be deemed to be the employer of IHSS personnel referred to recipients as described in Section 30-767.23 for the purposes of collective bargaining over wages, hours and other terms and conditions of employment.

.23 Any public authority or consortium shall provide the following minimum services:

30-767 SERVICE DELIVERY METHODS (Continued) **30-767**

.231 Provide registry services to recipients receiving services pursuant to Section 30-767.23.

(a) Assistance in finding providers through the establishment of a registry.

(b) Investigation of the qualifications and background of potential providers listed on the registry.

(c) Establishment of a referral system under which potential providers are made known to recipients.

.232 Provide access to training for providers and recipients.

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(a) Access to training for providers and recipients does not mean that the county or the Public Authority is under any obligation:

(1) to provide the training directly, to pay for training provided in the community, to pay for the provider's time to attend or to accompany the recipient to training, to pay for transportation to the training, or to pay for any materials required by the training; or

(2) to screen or be responsible for the content of any training it tells providers and/or recipients is available in the community; or

(3) to ensure that any provider or recipient attended/completed any training.

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.233 Perform any other function related to the delivery of IHSS.

.234 Ensure that the requirements of the Personal Care Services Program pursuant to Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code are met.

.24 Any public authority may adopt reasonable rules and regulations for the administration of employer-employee relations.

30-767 SERVICE DELIVERY METHODS (Continued) **30-767**

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.241 The Employer-Employee Relations Policy for Public Authorities Delivering In-Home Supportive Services is available from the California Department of Social Services as a model for public authorities. Public authorities may adopt, reject, or modify the policy in part or in its entirety.

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.25 Public authorities and consortia must submit cost reports and such other data as required for the Case Management, Information and Payrolling System (CMIPS).

.26 Any county that elects to provide for in-home supportive services pursuant to this section shall be responsible for any increased costs to the CMIPS attributable to such election. The Department shall collaborate with any county that elects to provide in-home supportive services pursuant to this section prior to implementing the amount of financial obligation for which the county shall be responsible.

.3 No recipient of any services specified in Section 30-757.14 or .19 shall be compelled to accept services from any specific individual, except for individuals recruited by the recipient's guardian, conservator, or, in the case of recipients who are minors, by their parents.

.31 For those recipients who are receiving services through the delivery methods described in .11 and .12 above, hiring preference shall be given to qualified persons recruited by the recipient to deliver services. For the purpose of this section a qualified person is one who meets the minimum requirements established by the contract agency or the County Civil Service or Merit Systems.

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.4 Personal Care Services Program Providers

DHS regulation Section 51181 reads:

Personal Care Services Provider.

A personal care services provider is that individual, county employee, or county contracted agency authorized by the Department of Health Services to provide personal care services to eligible beneficiaries. An individual provider shall not be a family member, which for purposes of this section means the parent of a minor child or a spouse.

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.5 Personal Care Services Program Provider Enrollment

DHS regulation Section 51204 reads:

Personal Care Services Provider.

All providers of personal care program services must be approved by Department of Health Services and shall sign the "Personal Care Program Provider/Enrollment Agreement" form [SOC 426 1/93)] designated by the Department agreeing to comply with all applicable laws and regulations governing Medi-Cal and the providing of personal care service. Beneficiaries shall be given a choice of service providers.

(a) Individual providers will be selected by the beneficiary, by the personal representative of the beneficiary, or in the case of a minor, the legal parent or guardian. The beneficiary or the beneficiary's personal representative, or in the case of a minor, the legal parent or guardian shall certify on the provider enrollment document that the provider, in the opinion of the beneficiary, is qualified to provide personal care so long as the person signing is not the provider.

(b) Contract agency personal care providers shall be selected in accordance with Welfare and Institutions Code Section 12302.1. The contract agency shall certify to the designated county department that the workers it employs are qualified to provide the personal care services authorized.

.6 Provider Audit Appeals

DHS regulation Section 51015.2 reads:

Providers of Personal Care Services Grievance and Complaints.

Notwithstanding Section 51015, when a provider of personal care services has a grievance or complaint concerning the processing or payment of money for services rendered, the following procedures must be met:

(a) The provider shall initiate an appeal, by submitting a grievance or complaint in writing, within 90 days of the action precipitating the grievance or complaint, to the designated county department identifying the claims involved and specifically describing the disputed action or inaction regarding such claims.

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30-767 SERVICE DELIVERY METHODS (Continued) **30-767**

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(b) The designated county department shall acknowledge the written grievance or complaint within 15 days of its receipt.

(c) The designated county department shall review the merits of the grievance or complaint and send a written decision of its conclusion and reasons to the provider within 30 days of the acknowledgment of the receipt of the grievance or complaint.

(d) After following this procedure, a provider who is not satisfied with the decision by the designated county department may seek appropriate judicial remedies in compliance with Section 14104.5 of the Welfare and Institutions Code, no later than one year after receiving notice of the decision.

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NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Sections 12301.6, 12302, 12302.1, and 14132.95, Welfare and Institutions Code and Section 54950 et seq., Government Code.

30-768 OVERPAYMENTS/UNDERPAYMENTS **30-768**

.1 Definition of Overpayment for Non-PCSP Payments

.11 Overpayment means that cash payment was made for the purchase of IHSS or services were delivered in an amount to which the recipient was not entitled.

.111 Services payments paid pending a state hearing decision as required by MPP 22-022.5 are not overpayments and cannot be recovered.

30-768 OVERPAYMENTS/UNDERPAYMENTS (Continued) **30-768**

.2 Amount of Overpayment for Non-PCSP Payments

When the county has determined that an overpayment has occurred, the county shall calculate the amount of overpayment as follows:

.21 Overpayment due to the recipient's failure to use total direct advance payment for the purchase of authorized hours.

.211 Authorization based on an hourly rate

a. Determine the number of service hours for which the recipient received a direct advance payment in excess of those service hours actually paid for.

b. Multiply this amount by the hourly wage rate used in computing the recipient's authorized payment.

.212 Authorization for a personal attendant

When services are delivered by a personal attendant, the amount of the overpayment is the difference between the amount that should have been paid and the amount which was actually paid.

.213 When the recipient receives a direct advance payment to purchase services in a given month, but fails to submit a reconciling time sheet within 45 days from the date of payment, there is a rebuttable presumption that the unreconciled amount is an overpayment.

.22 Overpayment due to excess service authorization

.221 Authorization based on an hourly rate

a. Determine the number of service hours for which payment was made in excess of the correct service authorization.

b. Multiply this amount by the county's lowest individual provider hourly wage rate regardless of the service delivery method used.

.222 Authorization for a personal attendant

When services are delivered by a personal attendant, the amount of overpayment is the difference between the amount paid and the amount which would have been paid if the service authorization was correct.

30-768 OVERPAYMENTS/UNDERPAYMENTS (Continued) **30-768**

.23 Overpayment due to incorrect share of cost

Where the correct share of cost was more than the recipient paid, the resulting overpayment is determined by subtracting the amount paid from the correct amount.

.24 Overpayment due to nonpayment of share of cost

Where the service hours were provided to the recipient, but he/she did not pay his/her obligated share of cost, the county should initiate overpayment recovery for the entire amount of the IHSS payment for the month in which the recipient was ineligible.

.25 Overpayment due to nonexpenditure of restaurant meal allowance

Where the recipient received an allowance for the purchase of restaurant meals, and used none of the allowance for that purpose, or if the recipient was ineligible for a restaurant meal allowance he/she received, the entire amount is an overpayment.

.3 Recovery of Overpayments for Non-PCSP Payments

.31 Limitations on amount of Recovery

.311 The repayment liability of the recipient shall be limited to the amount of liquid resources and income excluded or disregarded by the SSI/SSP Program. Liquid resources are cash or financial instruments that can be converted to cash, except funds set aside for burial.

.312 When an overpayment results from the recipient's failure to spend the entire amount of an advance direct payment for the purchase of authorized services, the difference in value between the hours purchased and the hours authorized shall be considered an available resource in determining repayment liability.

.32 Methods of Recovery

.321 The county may recover overpayments using any one or a combination of the methods listed below.

(a) Balancing

(1) Balancing means recovery of all or a portion of an overpayment by applying a repayable underpayment against it.

30-768 OVERPAYMENTS/UNDERPAYMENTS (Continued) **30-768**

(2) An underpayment shall not be balanced against an overpayment if the underpayment is discovered and payable prior to the time an overpayment is discovered and adjustable.

(b) Payment Adjustment

(1) Payment adjustment means that the county reduces payment for future authorized services to offset an overpayment.

(2) If the service payment is reduced to adjust for previous overpayments, the recipient shall be responsible for paying the current month's adjustment amount to the service provider in addition to any share of cost.

(c) Voluntary Cash Recovery

(1) Voluntary cash recovery means repayment voluntarily made to the county by a recipient who has incurred an overpayment.

(2) The recipient shall be given the option of voluntary cash repayment of all or a part of the amount to be adjusted in lieu of payment adjustment.

(d) Civil Judgment

The county shall have the authority to demand repayment and file suit for restitution for any unadjusted portion of an overpayment.

.33 Notice of Action

If the county determines that an overpayment has occurred as defined in .11 above and proposes to recover the overpayment, the county shall notify the recipient of the following:

.341 The period of time during which the overpayment occurred.

.342 The reason for the overpayment.

.343 The amount of overpayment and a description of how the amount was calculated.

.344 The method by which the county proposes to recover the overpayment.

.4 Definition of Underpayment for Non-PCSP Payments

.41 Underpayment means the recipient was entitled to more service than was authorized or that the share of cost paid by the recipient was greater than the correct amount.

30-768 OVERPAYMENTS/UNDERPAYMENTS (Continued) **30-768**

.411 An underpayment has occurred when the county has failed to determine the correct share of cost or authorize the correct amount of service when all essential information was available to the county.

.412 An underpayment has not occurred when there is a disagreement in the county's exercise of discretion or opinion, where discretion or opinion is allowed in the determination of the need for service.

.42 Amount of Underpayment

When the county has determined that an underpayment has occurred, the county shall calculate the underpayment as follows:

.421 Incorrect Service Authorization

(a) Subtract the number of hours actually authorized from the number of hours to which the recipient was entitled.

(b) Multiply this amount by the county's lowest individual provider hourly wage rate regardless of the service delivery method used.

.422 Share of Cost

When the correct share of cost was less than the recipient paid, the resulting underpayment is determined by subtracting the correct amount from the amount paid.

.423 Restaurant Meals

When the amount paid was less than the amount to which there was entitlement, subtract the amount paid from the correct amount.

.43 Method of Payment

.431 Underpayments shall be adjusted by an increase in the service authorization when the unauthorized service for which there was entitlement was yard hazard abatement or heavy cleaning, and the service was not previously provided through another source at no cost to the recipient.

.432 All other underpayments shall be corrected by a retroactive payment issued to the recipient in an amount equal to that of the calculated underpayment.

30-768 OVERPAYMENTS/UNDERPAYMENTS (Continued) **30-768**

.44 Notice of Action

If the county determines that an underpayment has occurred as defined in .4 above, the county shall notify the recipient of the following:

.441 The time period during which the underpayment occurred.

.442 The reason for the underpayment.

.443 The amount of the underpayment, and a description of how the amount was calculated.

.444 The method by which the county proposes to adjust the underpayment.

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.5 DHS regulation Section 50781 reads:

Potential Overpayments

(a) A potential overpayment occurs when any of the following conditions exist, as limited by (c).

(1) A beneficiary has property in excess of the property limits for an entire calendar month.

(2) A beneficiary or the person acting on the beneficiary's behalf willfully fails to report facts and those facts, when considered in conjunction with the other information available on the beneficiary's circumstances, would result in ineligibility or an increased share of cost.

(3) A beneficiary has other health coverage of a type designated by the Department [of Health Services] as not subject to post-service reimbursement, and the beneficiary or the person acting on the beneficiary's behalf willfully fails to report such coverage.

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30-768 OVERPAYMENTS/UNDERPAYMENTS (Continued) **30-768**

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(b) A beneficiary of the person acting on the beneficiary's behalf willfully fails to report facts if he/she has completed and signed a Medi-Cal Responsibilities Checklist, form MC 217, and a Statement of Facts and has, within his/her competence, done any of the following:

(1) Provided incorrect oral or written information.

(2) Failed to provide information which would affect the eligibility or share of cost determination.

(3) Failed to report changes in circumstances which would affect eligibility or share of cost within 10 days of the change.

(c) If a change occurred in a person's circumstances and that change could not have been reflected in the person's eligibility determination for the month in which the change occurred or the month following because of the 10 day notice requirements specified in Section 50179, no potential overpayment exists in that month or in the following month if appropriate.

.6 DHS regulation Section 50786 reads:

Action on Overpayment -- Department of Health Services or County Unit Contracted to Collect Overpayments

(a) Upon receipt of a potential overpayment referral, the Department's Recovery Section or the county unit contracted to collect overpayments shall:

(1) Determine the amount of Medi-Cal benefits received by the beneficiary for the period in which there was a potential overpayment.

(2) Compute the actual overpayment in accordance with the following:

(A) When the potential overpayment was due to excess property, the actual overpayment shall be the lesser of the:

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30-768 OVERPAYMENTS/UNDERPAYMENTS (Continued) **30-768**

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1. Actual cost of services paid by the Department during that period of consecutive months in which there was excess property throughout each month.

2. Amount of property in excess of the property limit during that period of consecutive months in which there was excess property throughout each month. This excess amount shall be determined as follows:

   a. Compute the excess property at the lowest point in the month for each month.

   b. The highest amount determined in a. shall be the amount of the excess property for the entire period of consecutive months.

(B) When the potential overpayment was due to increased share of cost, the actual overpayment shall be the lesser of the:

1. Actual cost of services received in the share of cost period which were paid by the Department.

2. Amount of the increased share of cost for the share of cost period(s).

(C) When the overpayment was due to excess property and increased share of cost, the actual overpayment shall be a combination of (A) and (B).

(D) When the potential overpayment was due to other factors which result in ineligibility the overpayment shall be the actual cost of services paid by the Department.

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30-768 OVERPAYMENTS/UNDERPAYMENTS (Continued) **30-768**

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(E) Potential overpayments, due to beneficiary possession of other health coverage that is not subject to post-service reimbursement, shall be processed by the Department to determine and recover actual overpayments in all cases. The actual overpayment in such cases shall be the actual cost of services paid by the Department which would have been covered by a private health insurance or other health coverage, had the coverage been known to the Department. The actual overpayment shall not include any costs which can be recovered directly by the Department from the health insurance carrier or other source.

(3) Refer those cases where there appears there may be fraud to the Investigations Branch of the Department.

(4) Take appropriate action to collect overpayments in accordance with Section 50787.

.7 DHS regulation Section 50787 reads:

Demand for repayment

(a) The Department or the county unit contracted to collect overpayments shall demand repayment or actual overpayments in accordance with procedures established by the Department.

(b) The Department or the county unit contracted to collect overpayments may take other collection actions as permitted under state law.

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NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Sections 10554, 12304.5 and 14132.95, Welfare and Institutions Code.

30-769 PAYROLLING FOR INDIVIDUAL PROVIDERS 30-769

.1 This section governs the procedures that shall be followed by counties making payments under the delivery method specified in Section 30-767.13. Counties shall not enter into any agreements or contracts to make payment to individual providers.

.2 County Responsibility

.21 The CRT counties shall directly input required data and initiate transactions into the system via terminals located in the county.

.22 The Paper counties shall input required data and initiate transactions on prescribed forms and submit those forms to the payrolling contractor.

.221 Exception: Special preauthorized transactions may be initiated by phone to the payrolling contractor. The prescribed document shall subsequently be sent from the payrolling contractor to the county confirming the transaction.

.23 For purposes of the payrolling system, the initial authorization period begins in the calendar month in which the first day of authorization occurs and continues until changed.

30-769 PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued) **30-769**

.24 General Process

.241 The counties shall:

(a) Enter prescribed data on all recipients and providers, as defined in Section 30-767.13, into the payrolling system.

(b) Change data as necessary to ensure correct payment to the correct individual.

(c) Authorize the disbursement of all funds paid by the payrolling contractor by:

(1) Reviewing all time sheets prior to entry of time sheet data into the system to ensure consistency between hours reported and hours authorized.

(2) Reviewing any significant discrepancies between hours reported and hours authorized to determine the reason and take corrective action as indicated.

(3) Initiating special transactions as described in .25 below.

(d) Retain completed time sheets as required by Section 23-353 in such a manner that they are easily accessible for review.

(e) Respond to and resolve payment inquiries from recipients and providers. The payrolling contractor will provide all necessary information.

.25 Special Transaction

.251 Special transactions are used to handle situations which fall outside the normal payroll process. Counties shall be held responsible for closely monitoring and controlling the use of the following transactions.

.252 The county shall initiate emergency/supplemental checks for:

(a) Payments resulting from retroactive state hearing decisions.

(b) Payments resulting from prior underpayments.

(c) Payments in excess of the base rate as provided in Section 30-764.

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30-769 PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued) **30-769**

(d) Payments for severely impaired recipients in advance pay status who become eligible for payment between a pay cycle.

(e) Payments where the county finds that an emergency situation exists.

(f) Payments to counties for reimbursements of emergency checks as described in .26 below.

(g) Payments for other unusual situations not provided for by the regular payrolling process and where the county deems appropriate.

(h) Payments for time sheets submitted three or more months beyond the current payroll cycle.

.253 A request for a replacement check shall be made expeditiously by the county but no sooner than five (5) days from the date the original check should have been received.

.254 A void transaction shall be used:

(a) When a payroll check is returned to the payrolling contractor or county.

(b) When a payroll check is mutilated.

(c) When a payroll check is not in the possession of the county or the payrolling contractor.

.255 Adjustment transactions shall be used to make adjustments to tax records when any of the following occur:

(a) An overpayment.

(b) An underpayment.

(c) An incorrect deduction.

.26 County issued payments shall only be issued in cases of extreme emergency when the county finds that the emergency check procedure provided in .252 is not adequate.

30-769 PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued) **30-769**

.261 The county shall issue checks for an amount not to exceed ninety (90%) percent of the amount the recipient/provider should receive.

.262 The county shall be reimbursed for payments made under .261 above by the payrolling contractor using the emergency/supplemental check transaction.

.263 The county shall not receive reimbursement until an emergency/ supplemental transaction has been initiated to pay the recipient/ provider the remaining balance.

.264 The county shall receive a time sheet before the transaction in .261 or .263 above shall occur. Exception: The county may issue a check prior to receipt of a time sheet for a severely impaired recipient who opted for advance pay.

.27 The counties shall be responsible for verifying eligibility of recipients for IHSS between January 1, 1978 and December 31, 1979 as needed for retroactive tax payments.

.28 The county shall ensure that all providers are informed of the requirements they must meet in order to be paid.

.3 The County Has The Sole Responsibility For Determining And Investigating Fraud And Forgery for Non-PCSP

.31 The county shall, with no effect on current county procedures:

.311 Identify suspected fraud cases;

.312 Determine if actual fraud exists;

.313 Take appropriate action as necessary.

.32 The county will be notified by the payrolling contractor if an original check has already been cashed when a replacement check is requested. The county shall then follow the applicable procedure in the user's manual.

.4 PCSP Fraud or Forgery

30-769 PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued) **30-769**

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.41 DHS regulation Section 50782 reads:

Fraud occurs if an overpayment occurs and the beneficiary or the person acting on the beneficiary's behalf willfully failed to report facts as specified in Section 50781(b) with the intention of deceiving the Department, the county department or the Social Security Administration for the purpose of obtaining Medi-Cal benefits to which the beneficiary was not entitled.

.42 If PCSP fraud or forgery occurs, DHS will follow the procedures cited in DHS regulation Section 50793.

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.5 Return Check Procedures

.51 Counties which receive a returned check from a provider or recipient shall follow the applicable procedures in the user's manual.

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30-769 PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued) **30-769**

.6 Refunds/Recoupment

.61 Counties which receive refunds or recoupments shall:

.611 Deposit the money received in a county account; and

.612 Send a monthly check to the payrolling contractor for the amount of refund/recoupment received during the previous month in accordance with applicable procedures in the User's Manual.

.7 Recipient Responsibility

.71 It is the responsibility of the recipient to report to social services staff accurately and completely all information necessary to complete the SOC 311.

.72 The recipient, within his/her physical, emotional, educational or other limitations, shall:

.721 Designate the authorized hours per provider within the total of the recipient's authorized hours.

.722 Designate each provider(s) portion of the share of cost.

.723 Sign and date the prescribed time sheet to:

(a) Verify payment of the share of cost to the appropriate provider(s).

(b) Verify that services authorized where rendered by the appropriate provider.

.724 Inform social services staff of any changes affecting the payrolling process.

.73 Payments for authorized services rendered shall be sent to the recipient's appropriate provider. The recipient shall not receive payment for services except as provided in .731 through .734 below.

.731 Severely impaired recipients as defined under Section 30-753, shall have the option of choosing to directly receive their payment at the beginning of each authorized month. Such payment shall be the net amount exclusive of the appropriate withholdings.

30-769 PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued) **30-769**

.732 In direct payment cases, where a recipient is incapable of handling his/her financial and legal affairs and has a legal guardian or conservator, direct payment shall be made to the recipient's legal guardian or conservator at such person's request.

.733 Payment may be made to a recipient's guardian, conservator, substitute payee, or person designated by the recipient.

.734 When payment is made as a result of a state hearing decision.

.735 If the recipient is severely impaired he/she shall be notified in writing of the right to hire and pay his/her own provider, and to receive his/her monthly cash payment in advance.

.736 When direct payment is made to a recipient, guardian, conservator, or substitute payee, the provider shall be hired, supervised, and paid by such payee. In such cases, the recipient or the person authorized to act in the recipient's behalf shall insure that the services provider is capable of and is providing the services authorized.

.737 It shall be the responsibility of the severely impaired recipient, legal guardian or conservator who receives payment in advance to submit their provider's time sheets at the end of each authorized service month to the appropriate county social services office.

.8 Provider Benefits

.81 The department has elected to provide the worker's compensation coverage required by Welfare and Institutions Code Section 12302.2 through a single statewide insurance policy. Additional insurance coverage will not be reimbursed as an IHSS program cost.

.82 The department has elected to handle the payment of the unemployment insurance tax, unemployment disability insurance tax, and social security tax required by Welfare and Institutions Code Section 12302.2 through the payrolling system.

.83 The department has elected to require the payrolling contractor to deduct the employee's share of the following taxes from the payment to the provider or the recipient:

30-769 PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued) **30-769**

.831 Social security.

.832 State disability insurance.

.84 The department has elected to deduct and transmit the state and federal income tax withholdings due on the provider's earnings for those providers who voluntarily request this service.

.9 Excessive Compensation

(See Section 30-769.91 (Handbook) for examples of excessive compensation)

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.91 Excess compensation to an individual provider but is not necessarily limited to the following circumstances:

.911 The provider was paid for more hours than authorized or more hours than worked.

.912 The provider was paid at a higher hourly rate than appropriate.

.913 The share of cost withheld from provider's payment was less than the recipient affirms was paid to the provider.

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.92 All excess provider compensation is recoverable. The county shall demand repayment from the provider. The county shall be permitted to seek recovery of excess compensation by civil suit.

.93 Provider Fraud or Forgery

If the county suspects that excess provider payment occurred because of fraudulent devices of the provider, forgery, or collusion between the provider and the recipient, the county shall investigate the suspected fraud, forgery, or collusion. If the facts warrant prosecution and the county does not have an investigative unit, the county shall refer the matter directly to the county district attorney's office for investigation and possible prosecution.

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Section 14132.95, Welfare and Institutions Code.

30-770 ELIGIBILITY STANDARDS 30-770

.1 Persons applying for IHSS under Sections 30-755.112, .113 and .114 shall meet the SSI/SSP eligibility standards except as modified by Section 30-755.1.

.2 Detailed eligibility standards shall be those located in 20 CFR Part 416, except as modified by IHSS regulations beginning with Section 30-750.

.3 Definitions.

.31 For the purposes of eligibility for IHSS, a child means an individual who is neither married nor the head of a household, and who is under the age of 18, or under the age of 22 and a student regularly attending a school, college, or university, or a course of vocational or technical training designed to prepare him/her for gainful employment.

.311 For the purposes of deeming for IHSS, a child means an individual who is neither married nor the head of a household, and who is under the age of 18.

.312 Regularly attending school means being enrolled in eight semester or quarterly hours weekly in a college or university, or 12 hours weekly in a secondary school. In a course of vocational or technical training, 15 clock hours weekly are required; without shop practice, at least 12 hours weekly are required.

.313 Eligible spouse means an aged, blind, or disabled individual who is the husband or wife of another aged, blind, or disabled individual who has not been living apart from such other aged, blind, or disabled individual for more than six months.

.4 Residency

.41 Residency in State Required

To be eligible for IHSS, an individual shall be a U.S. citizen, or an eligible alien pursuant to Welfare and Institutions Code Section 11104. The individual shall also be a California resident, physically residing in the state except for temporary absence as noted below in Sections 30-770.42 through .45, with the intention to continue residing here.

30-770 ELIGIBILITY STANDARDS (Continued) **30-770**

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Welfare and Institutions Code Section 11104 states:

"Aliens shall be eligible for aid only to the extent permitted by federal law.

"An alien shall only be eligible for aid if the alien has been lawfully admitted for permanent residence, or is otherwise permanently residing in the United States under color of law. No aid shall be paid unless evidence as to eligible alien status is presented."

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.42 Physical Absence from the State

Physical absence from the state indicates a possible change of state residence. The county shall make inquiry of a recipient who has been continuously absent from the state for 30 days or longer in order to ascertain the recipient's intent to maintain California residency. If the inquiry establishes that the recipient is no longer a California resident, authorization for IHSS shall be discontinued.

.421 The county inquiry to the recipient will require the recipient to submit a written statement that:

(a) Declares his/her anticipated date of return to the state, or his/her intent not to return to the state;

(b) Declares his/her reason for continued absence from the state; and

(c) Provides needed information on his/her location and status of household arrangements.

.422 The county will include in the inquiry to the recipient a statement that his/her failure to respond to the inquiry by a specified date will result in his/her ineligibility and the discontinuation of IHSS.

30-770 ELIGIBILITY STANDARDS (Continued) **30-770**

.43 Evidence of Residence Intention

.431 The written statement of the recipient is acceptable to establish his/her intention and action on establishing residence unless the statement is inconsistent with the conduct of the person or with other information known to the county.

.432 If the recipient does not respond by the specified date to the inquiry of residence, it shall be presumed that he/she does not intend to maintain California residency, and authorization for IHSS shall be discontinued when the absence exceeds 60 days in accordance with regulations (Sections 30-759.7 and 10-116).

.433 If the recipient responds to the inquiry and advises the county that he/she does not intend to return to California, authorization for IHSS shall be discontinued in accordance with regulations.

.44 Absence from State for More than 60 Days

.441 If the recipient responds to the inquiry and advises the county that he/she intends to maintain his/her California residence, but he/she remains or has remained out of state for 60 days or longer, his/her continued absence is prima facie evidence of the recipient's intent to have changed his/her place of residence to a place outside of California, unless he/she is prevented by illness or other good cause from returning to the state at the end of 60 days. Such absence in itself is sufficient evidence to support a determination that the recipient has established residence outside of California. Therefore, his/her intent to return must be supported by one or a combination of the following:

(a) Family members with whom the recipient lived, currently live in California;

(b) The recipient has continued maintenance of his/her California housing arrangements (owned, leased, or rented);

(c) The recipient has employment or business interest in California;

(d) Any other act or combination of acts by the recipient which establishes his/her intent to reside in California.

30-770 ELIGIBILITY STANDARDS (Continued) **30-770**

.442 Even if the recipient's intent to reside in California is supported by .441 above, the following evidence shall be utilized to determine the recipient's intent to reside in California:

(a) The recipient has purchased or leased a place of residence out of state since leaving California;

(b) The recipient has been employed out-of-state since leaving California;

(c) The recipient has obtained an out-of-state motor vehicle driver's license after leaving California;

(d) The recipient has taken any other action which indicates his/her intent to establish residence outside of California.

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.443 Welfare and Institutions Code Section 1110 states that if a recipient is prevented by illness or other good cause from returning to California at the end of 60 days, and has not by act or intent established residence elsewhere, he shall not be deemed to have lost his residence in this state. The following is added by Welfare and Institutions Code Section 11100.1(a):

For purposes of the In-Home Supportive Services Program ..."good cause," as defined in Section 11100, shall include, but is not limited to, the following:

(1) Outpatient medical treatment necessary to maintain the recipient's health where the medical treatment is not available in California.

(2) Short-term schooling or training necessary for the recipient to obtain self-sufficiency where training which would achieve that objective is not available or accessible in California.

(3) Court-issued subpoena or summons.

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30-770 ELIGIBILITY STANDARDS (Continued) **30-770**

(a) For outpatient medical treatment out of state, good cause for continuing to receive benefits while absent from the state for more than 60 days shall also include the situation where the medical treatment is not accessible in California.

(b) Accessible in these regulations means attainable for the recipient in California, given the dysfunctioning and needs of the recipient.

(c) Other good cause reasons for continuing to receive IHSS benefits while absent from the state for over 60 days shall be consistent with the good cause reasons contained in Welfare and Institutions Code Section 11100.1.

(1) The situation shall be of an urgent or emergency nature:

(2) The service required shall be necessary to maintain the physical or psychological health of the recipient:

(3) The services required or like services shall be either not available or not accessible in California.

.444 A recipient absent from California for more than 60 days and who is not prevented from returning to this state because of illness or other good cause shall have his/her authorization for IHSS discontinued in accordance with regulations.

.45 Absence from the State Exceeding Six Months

.451 Authorization for IHSS shall be suspended for any recipient who leaves the state and who remains absent from the state for a period which exceeds six months, notwithstanding the fact that the recipient has continued to receive IHSS benefits beyond 60 days because he/she was prevented from returning to the state due to illness or other good cause, as specified in Sections 30-770.43 and .44. Suspension of benefits will be in accordance with notice of Action regulations contained in Sections 30-759.7 and 10-116.

30-770 ELIGIBILITY STANDARDS (Continued) **30-770**

.452 In-Home Supportive Services shall not be resumed until the recipient, upon returning to the state, requests a reassessment of need from the county, and the reassessment has been completed in accordance with regulations (Section 30-763).

.46 Outside the United States While Absent from the State

.461 In-Home Supportive Services shall be discontinued for any recipient who is outside the United States for all of any month, or for 30 days in a row, as such an individual is no longer eligible to receive SSI/SSP. Discontinuation of benefits will be in accordance with notice of action regulations.

(a) Upon the individual's return to the United States, and upon his/her reestablishment as an SSI/SSP recipient, an SSI/SSP eligible recipient, or an individual who would be eligible for SSI/SSP except for excess income, he/she may again apply for IHSS benefits. The county shall redetermine IHSS eligibility and perform a needs assessment based on current circumstances.

(b) "United States" includes the 50 states, the District of Columbia, and the Northern Mariana Islands.

.47 Continuation of IHSS While Absent from the State

.471 When the county has determined that the recipient is entitled to the continuation of IHSS benefits while absent from the state (the recipient is absent from the state for 60 or more days and is prevented from returning due to illness or other good cause, as determined in Sections 30-770.42, .43, and .44), the following apply:

(a) The recipient shall continue to receive the same number of hours of IHSS that were authorized prior to his/her temporary absence. This level of authorization will continue until a reassessment is required.

(b) The recipient's out-of-state individual provider (IP) shall be reimbursed at the county's lowest current IP base rate.

(c) The recipient must continue to mail time sheets to the county as required by regulations.

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30-771 LINKAGE 30-771

.1 Aged - An aged individual shall be considered to be one who is 65 years of age or older.

.2 Blindness - An individual shall be considered to be blind for purposes of IHSS if:

.21 He/she has central visual acuity of 20/200 or less in the better eye with use of a correcting lens. An eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered as having a central visual acuity of 20/200 or less.

.22 He/she is blind as defined under the state plan approved under Title X as in effect for October 1972 and received aid under such plan on the basis of blindness for December 1973, provided that he/she is continuously so defined.

.3 Disability - An individual shall be considered to be disabled for the purposes of IHSS if one of the following applies:

.31 He/she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or can be expected to last for a continuous period of not less than 12 months.

.32 In the case of a child under the age of 18, if he/she suffers from any medically determinable physical or mental impairment of comparable severity.

.33 He/she is permanently and totally disabled as defined under a state plan approved under Title XIV as in effect for October 1972 and received aid under such plan on the basis of disability for at least one month prior to July 1973 and for December 1973, provided that he/she is continuously disabled as so defined.

.4 Additional criteria regarding aged, blindness and disabled eligibility shall be applied as outlined in 20 CFR 416, Subpart 1.

30-773 RESOURCES 30-773

.1 All resources, both liquid and non-liquid, shall be evaluated based upon their equity value with the exception of automobiles, which shall be evaluated as specified in .6(c) below.

.2 Each aged, blind, or disabled individual whose eligibility for aid commenced on or after January 1, 1974 may have countable resources not in excess of $1,500 in value and be eligible.

.3 An individual who is living with either an eligible or ineligible spouse may have countable resources not in excess of $2,250 in value and remain eligible.

.31 The $2,250 limitation includes the resources of such spouse.

.4 The resources of a recipient child who is living with his/her parent, parents, or parent and spouse of parent, shall be deemed to include that portion of the countable resources of his/her parent(s) and spouse of parent which exceeds $1,500 in value in the case of one parent, or $2,250 in value in the case of two parents or parents or parent and spouse.

.41 For the purposes of this section, a recipient child is an unmarried person under the age of 18.

.5 Individuals receiving AB, ATD, or OAS in December 1973, including individuals who applied for aid in December 1973 and met all the conditions of eligibility for payment in that month, shall continue to be subject to the property limitations in effect in December 1973 unless the recipient would be advantaged by the regulations regarding resource limitations currently in effect.

.6 In determining the countable resources of an individual, and spouse if any, the following items shall be excluded:

(a) The home.

(b) Household goods and personal effects to the extent that the combined equity value does not exceed $2,000. Where the equity value exceeds $2,000, the excess shall be counted toward the resources limitation.

30-773 RESOURCES (Continued) **30-773**

(c) Automobiles, as defined in 20 CFR 416, Subpart L.

(1) One automobile shall be totally excluded regardless of its value if, for the individual or a member of the individual's household, one of the following applies:

(A) It is necessary for employment.

(B) It is necessary for transportation to a site for medical treatment of a specific ongoing medical problem.

(C) It is modified for operation by or transportation of a handicapped person.

(2) If no automobile is excluded under (1) above, one automobile shall be excluded from counting as a resource to the extent its current market value does not exceed $4,500.

(A) If the market value exceeds $4,500, the excess shall be counted against the resources limitation.

(3) When the recipient or spouse has more than one automobile, such additional automobile(s) shall be treated as non-liquid resources and shall be counted to the extent of their equity value unless they are the property of a trade or business, or are nonbusiness properties which are essential to the means of self-support, as provided in (d) and (e) below.

(d) Property of a trade or business which is essential to the means of self-support, as provided in federal guidelines.

(e) Nonbusiness property which is essential to the means of self-support, as provided in federal guidelines.

(f) Resources of a blind or disabled individual which are necessary to fulfill a plan for achieving self-support as described in Section 30-775.436.

(g) Life insurance if the face value does not exceed $1,500. If the face value exceeds $1,500, the entire cash surrender value of the insurance shall be counted toward the resources limitation. Term insurance and burial insurance shall be totally excluded.

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30-773 **RESOURCES** (Continued) 30-773

(h) Any other resources deemed excludable by the Secretary of Health and Human Services under the provisions of Title XVI of the Social Security Act.

(i) Restricted allotted land owned by an enrolled member of an Indian tribe.

(j) Per capita payments distributed pursuant to any judgment of the Indian Claims Commission or the Court of Claims in favor of any Indian tribe as specified in Public Law 93-134.

(k) Shares of stock and money payments made to Alaskan Natives under the Alaskan Native Claims Settlement Act provided that the payments or stock remain separately identifiable and are not commingled with nonexempt resources. Any property obtained from stock investments under the Act shall not be exempt.

(l) Tax rebates, credits or similar temporary tax relief measures which state or federal laws specifically exclude from consideration as a personal property resource. The specific rebates and credits listed in Section 30-775.42(a) shall also be exempt as property provided that the monies retained are not commingled and are separately identifiable as a proportionate share of the recipient's property.

(m) Otherwise countable resources shall be exempt up to the amount of benefits paid on behalf of the applicant/recipient for long-term care services under a State certified long-term care insurance policy or certificate, certified by the State to provide such exemption.

(1) Any income generated by such exempt property is countable as income in the month received. See Section 30-775.

30-773 **RESOURCES** (Continued) 30-773

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(A) An example of income generated by such exempt property would be rental income generated by an exempt resource.

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(2) The burden shall be rebuttably presumed to have been met if the applicant/recipient presents a "SERVICE SUMMARY" signed by a representative of the insurance company verifying that the applicant/recipient is a holder of an insurance policy or certificate certified by the State to provide the exemption, and specifying the total amount of qualifying benefits paid out under the policy to date.

(3) The amount of the qualifying benefits stated to have been paid in the "SERVICE SUMMARY" referred to in Section 30-773.6(m)(2) shall be the amount of the exemption to which the applicant/recipient is entitled.

(4) If the statement by the insurance company is found to be erroneous, the county shall promptly notify the California Department of Health Services.

(5) If the statement by the insurance company is such that the county cannot determine whether the applicant/recipient is covered by a qualifying policy or the amount of the benefits paid out on behalf of the beneficiary, the county shall deny the exemption. When an exemption is denied, the county shall refer the recipient to the California Department of Health Services for assistance and shall notify the California Department of Health Services of the reasons for this determination.

30-773 **RESOURCES** (Continued) 30-773

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(6) This is a sample of a SERVICE SUMMARY as referred to in Section 30-773.6(m)(2). The service summary is a form required by the California Department of Health Services. (See Title 22, Sections 58032 and 58080.)

(Company letterhead with company seal)

Name of Insured _____ Date of Birth _____

Social Security Number _____

Address of Insured _____

Policy Number _____ Issue Date _____

Insurance Company _____

SERVICE SUMMARY:	The Total Amount of Benefits Paid for Long-Term Care Services Countable toward the Medi-Cal Property Exemption	$91,000

To the Insured: This summary provides you with the total amount of insurance payments that count towards the Medi-Cal Property Exemption to be applied in determining eligibility for the State of California's Medicaid (Medi-Cal) Program. Please examine this summary and carefully compare your current asset total with the amount. If the amount of your Medi-Cal Property exemption is close to the amount of the assets you currently have, you may be eligible for the Medi-Cal Program. It is your responsibility to make application to the county (usually the Department of Social Services) for such eligibility. At the time of your application, a determination will be made whether and when you are eligible. (Please note: You may have assets, in addition to the Property Exemption listed above, that are exempted from the determination of Medi-Cal eligibility.)

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30-773 RESOURCES (Continued) **30-773**

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To the County: This summary verifies that the amount indicated with the label "SERVICE SUMMARY" was paid by (company name) for long-term care services as defined in California Code of Regulations, Title 22, Section 58023 on behalf of the person whose name appears as the "Name of Insured" above. This amount is exempt from the determination of Medi-Cal eligibility pursuant to California Code of Regulations, Title 22, Section 50453.7. If such person is found eligible for Medi-Cal by applying the Medi-Cal Property Exemption amount reported in this summary and after receiving Medi-Cal services is found to be ineligible solely by reason of errors in this summary, the Department of Health Services may recover from (company name) the amount of service payments as provided in California Code of Regulations, Title 22, Section 58082(e).

(Name and Title) _____ (date) _____

(Company Name) _____

HANDBOOK ENDS HERE

.7 Disposition of Resources.

.71 Although an individual's resources, including those of his/her spouse, exceed the limits imposed in .2 through .4 above, he/she shall be eligible for IHSS during the period of disposition of such excess resources provided that he/she meets other eligibility criteria, including those specified in this section.

.711 In no event shall total countable resources exceed $3,000 in value for an individual, or $4,500 in value for an individual and spouse. Total countable liquid resources shall not exceed $714 for an individual or $1,071 for an individual and spouse.

.72 The applicant or recipient shall agree in writing to dispose of the excess resources within the time limit specified in .74 below and to repay any overpayments with the proceeds of the disposition.

30-773 RESOURCES (Continued) **30-773**

.73 During the period that the excess property is held and is under disposition, in accordance with the individual's agreement to dispose of the property, any IHSS payments made shall be considered to be overpayments.

.731 The net proceeds from the disposition of the excess property shall be considered to be available for liquidation of overpayments occurring during the disposition period in accordance with Section 30-768.3.

.74 The disposition of the excess property shall be accomplished within a six-month period in the case of real property and within three months in the case of personal property.

.741 The time period shall begin on the date the agreement is signed by the individual.

(a) In the case of a disabled individual, the time period shall begin on the date of the disability determination.

.742 The time limits may be extended another three months where it is found that the individual had "good cause" for failing to dispose of the property within the original time period.

(a) "Good cause" shall exist if, despite reasonable and diligent effort on his/her part, he/she was prevented by circumstances beyond his/her control from disposing of the property.

NOTE: Authority cited: Section 22009(b), Welfare and Institutions Code. Reference: Section 22004, Welfare and Institutions Code.

30-775 INCOME **30-775**

.1 Income means the money or other gain periodically received by an individual for labor or service, or from property, investment, operations, etc. Income may be in the form of cash, including checks and money orders; in-kind items; real property; or personal services.

.11 When the item of receipt is not in the form of cash, the cash equivalent shall be determined.

.12 An individual's or individual and eligible spouse's income shall include all of his/her or their income in cash or in-kind, both earned and unearned.

30-775 **INCOME** (Continued) 30-775

.13 An individual's income shall also include those amounts of income of his/her eligible spouse, or, if the individual is a child as defined in Section 30-770.3, of his/her parent and parent's spouse residing in the same household.

.14 If income after applying the allowable disregards or exclusions exceeds the appropriate SSI/SSP benefit level, the excess shall be applied to the cost of IHSS.

.2 Earned Income

.21 Earned income means:

.211 Gross wages.

.212 Net earnings from self-employment.

(a) Net earnings shall be determined by deducting from gross earnings from self-employment all ordinary and necessary business expenses. Principal payments on encumbrances and personal income taxes shall not be considered expenses. Schedules attached to Form 1040 of the IRS for various types of self-employment may be used to verify allowable expenses.

.213 Those amounts of countable earned income deemed to be available to the individual from the income of his/her ineligible spouse, or parent(s) in the case of a recipient child.

(a) When a parent and recipient child live in a household with the parent's spouse, who is not the parent of the child, the income of the parent's spouse shall also be deemed to the child.

(b) Deeming procedures shall conform to those specified in 20 CFR 416.1185, as set forth on the form(s) developed and approved by the department.

.3 Unearned Income.

.31 Unearned income means all other available income.

.32 In evaluating the amount of unearned income which is available to the individual, consideration shall be given to any necessary costs involved in obtaining or securing the income.

30-775 INCOME **30-775**

.33 Unearned income includes, but is not limited to, the following:

.331 Support and maintenance furnished in cash or in-kind.

(a) A person who meets the criteria in Section 46-325.51 shall have the household of another SSI/SSP benefit level used to compute share of cost in lieu of counting the support and maintenance as unearned income.

(1) A person subject to the above procedure may still be eligible for IHSS if living in his/her own home as defined in Section 30-753.

.332 Any payments received as an annuity, pension, retirement, disability, OASDI, unemployment, veteran's or workmen's compensation benefit.

.333 Prizes and awards.

.334 Gifts, support and alimony payments, and inheritances.

.335 Rents, dividends, interests, and royalties.

.336 The proceeds of any life insurance policy to the extent that they exceed the amount expended by the beneficiary for purposes of the insured individual's last illness and burial expenses or $1,500, whichever is less.

.337 Those amounts of countable unearned income deemed to be available to the individual from the income of his/her ineligible spouse or parent(s) in the case of a recipient child.

(a) When a parent and recipient child live in a household with the parent's spouse, who is not the parent of the child, the income of the parent's spouse shall also be deemed to the child.

(b) Deeming procedures shall conform to those specified in 20 CFR 416.1185, as set forth on the form(s) developed and approved by the department.

30-775 INCOME (Continued) **30-775**

.4 Payments Excluded or Disregarded in Considering Income.

.41 In determining the eligibility for and amount of IHSS, certain payments received or portions thereof shall not be counted as income to the individual and eligible spouse. These exclusions shall also apply in deeming from an ineligible spouse or, in the case of a recipient child, the ineligible parent(s).

.42 The following items shall be excluded from consideration as income:

(a) Refunds, credits and rebates of taxes.

(1) Refunds of taxes paid on real property or purchased food received from any public agency, or renter's credit payments, or special tax credit payments for renters 62 years and older.

(2) Tax rebates, credits or similar temporary tax relief measures which state or federal law specifically exclude from consideration as income.

(b) Assistance based on need.

(1) Payments which are composed entirely of state or local government funds, when made under a program using income level as a criteria for determining the amount of such payment.

(A) When federal or nonpublic monies are included in the assistance payment, such payments shall be countable, including AFDC payments to federally eligible persons, which are countable on a dollar-for-dollar basis related to the recipient's pro rata share.

(c) Grants, scholarships, and fellowships.

(1) Any portion of any grant, scholarship, or fellowship received, used or to be used in paying tuition and fees at any educational institution, including technical or vocational.

30-775 INCOME (Continued) **30-775**

(d) Home produce.

(1) The value of agricultural products which are not raised in connection with a trade or business and are utilized for consumption by the household.

(A) If the produce is sold, the net earnings shall be countable as earned income.

(e) Foster care payments.

(1) Payments for the foster care of a child who is not an eligible individual but who resides in the same home as such individual and was placed there by a public or nonprofit agency.

(f) Support payment from an absent parent.

(1) One-third of any payment received from an absent parent for an eligible individual who is a child as defined in Section 30-770.3.

(A) The remainder shall be countable as unearned income.

(g) Readers and educational scholarships for the blind.

(1) Funds, not available to meet basic needs, awarded for readers and educational scholarships by a high school, institution of higher learning, or a vocational or technical training institution to a recipient due to his/her blindness while he/she is regularly attending any public school or any institution of higher learning in this state.

(h) Vendor payments.

(1) Payments made from any source to a vendor in order to meet the needs of the recipient for medical or social services, as determined by the county welfare department. When the vendor is the recipient's spouse, the provisions of .213 above shall apply.

30-775 **INCOME** (Continued) 30-775

(i) CETA incentive payments.

(1) Up to $30 per week of the incentive allowances made to trainees under Title I of the Comprehensive Employment and Training Act (CETA).

(A) This exemption shall apply to any CETA trainee whose needs or income are taken into account in determining the amount of public assistance payments to himself/herself or others.

(B) This exemption shall not apply to wages or other training allowances under the Act.

(j) Payments to Indians.

(1) Per capita payments distributed pursuant to any judgment of the Indian Claims Commission or the Court of Claims in favor of any Indian tribe as specified in Public Law 93-134.

(A) This exemption shall apply to anyone whose income is taken into account to determine the eligibility or grant of a recipient.

(k) Payments made to Alaskan Natives.

(1) Shares of stock and money payments made to Alaskan Natives under the Alaskan Native Claims Settlement Act.

(A) Income resulting directly from stock investments under the Act shall not be exempt.

(l) Supportive services payments.

(1) Payments for supportive services or reimbursement of out-of-pocket expenses made to persons serving in the Service Corps of Retired Executives (SCORE) and the Active Corps of Executives (ACE) pursuant to Section 418 of Public Law 93-113.

(A) This exemption shall apply to all persons whose income is taken into account in determining the amount of the IHSS payment.

30-775 INCOME (Continued) 30-775

(m) Domestic Volunteer payments.

(1) Payments made under the Domestic Volunteer Services Act of 1973 to welfare recipients who are VISTA volunteers.

(n) Supplemental food assistance.

(1) The value of supplemental food assistance received under the Child Nutrition Act (WIC) and the National School Lunch Act, as specified in Public Laws 92-433 and 93-150.

(o) Energy assistance allowances.

(1) Payments or allowances made under any federal, state or local laws for the purpose of energy assistance, e.g., Low Income Energy Assistance Program (EAP), Energy Crisis Assistance Program (ECAP), and Crisis Intervention Programs (CIP) payments.

(A) Such payments or allowances shall be clearly identified as energy assistance by the legislative body authorizing the program or providing the funds.

.43 The following disregards shall be applied in the order listed below:

.431 Infrequent or irregular income.

(a) Unearned income.

(1) Unearned income which does not exceed $60 per quarter and is received not more than once per quarter or cannot be reasonably anticipated.

(b) Earned income.

(1) Earned income which does not exceed $30 per quarter and is received not more than once per quarter or cannot be reasonably anticipated.

.432 Student exemption.

(a) Up to $1,200 per calendar quarter of the earned income of the recipient who is a child and a student, but in no instance more than $1,620 per calendar year.

30-775 INCOME (Continued) **30-775**

.433 The first $20 per month.

(a) The first $20 of earned or unearned income per month not disregarded above. If the eligible individual or individual and eligible spouse has:

(1) Only earned income, the disregard shall be applied to that income.

(2) Only unearned income, the disregard shall be applied to that income.

(3) Both types of income, the disregard shall first be applied toward the unearned income, and any amount of the disregard remaining shall be applied to the earned income.

.434 Earned income.

(a) The first $65 per month of earned income not disregarded above plus one-half of the remainder.

.435 Work expenses of the blind.

(a) Earned income not disregarded above of a blind individual in the amount of ordinary and necessary expenses related to work activity, and only to the extent that they are paid or to be paid. Broad categories of expenses shall include but not be limited to the following:

(1) Transportation to and from work.

(2) Job performance.

(3) Qualification for promotion.

.436 Income necessary to achieve self-support.

(a) Earned or unearned income not disregarded above and received by an individual who is blind or disabled as defined in Sections 30-771.2 and .3 to the extent that such income is needed to implement a plan of self-support.

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30-775 INCOME (Continued) **30-775**

(1) Such plan shall be in writing and shall be approved by the United States Social Security Administration (SSA) unless a state-approved plan is still in effect when the blind or disabled individual becomes eligible for IHSS.

(2) The plan shall contain the following elements:

(A) Specific savings and/or disbursement goals for a designated occupational objective.

(B) Identification and segregation of such money and other resources as are being accumulated and conserved toward this goal.

.437 Income exclusions for certain blind individuals.

(a) For an individual who is blind as determined under the state plan approved until Title X as in effect in October 1972, and who received assistance under such plan in December 1973, an amount equal to the greater of the following:

(1) The maximum amount of any earned or unearned income which could have been disregarded under the state plan as in effect in October 1972; or

(2) The amount which would be required to be disregarded under .4 above without application of this subsection.

30-776 PROVIDER IDENTIFICATION **30-776**

.1 Proof of provider identification shall be required pursuant to Welfare and Institutions Code Section 12306.5.

30-776 PROVIDER IDENTIFICATION (Continued) **30-776**

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Welfare and Institutions Code Section 12306.5 states that any public or private agency, including a contractor as defined in Welfare and Institutions Code Section 12302.1, who maintains a list or registry of prospective In-Home Supportive Services providers shall require proof of identification from a prospective provider prior to placing the prospective provider on a list or registry or supplying a name from the list or registry to an applicant for, or recipient of, In-Home Supportive Services.

HANDBOOK ENDS HERE

.11 Proof of identification shall not be required for prospective providers to remain on a list or registry that existed before April 1, 1988. However, proof of identification shall be required prior to providing those prospective providers' names to an applicant or recipient of In-Home Supportive Services, or prior to providing the names of any prospective providers where proof of identification has not been established.

.12 Proof of identification shall include, but is not limited to, one of the following:

.121 A positive photograph identification from a government source, such as:

(a) a valid California driver's license;

(b) a valid identification card issued by a government agency; or

(c) a valid military identification card.

.122 A valid student identification card issued by an accredited college or university.

30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY 30-780

HANDBOOK BEGINS HERE

.1 Scope of Services

DHS regulation Section 51183 reads:

Personal Care Services.

Personal care services include (a) personal care services and (b) ancillary services prescribed in accordance with a plan of treatment.

(a) Personal care services include:

(1) Assisting with ambulation, including walking or moving around (i.e. wheelchair) inside the home, changing locations in a room, moving from room to room to gain access for the purpose of engaging in other activities. Ambulation does not include movement solely for the purpose of exercise.

(2) Bathing and grooming including cleaning the body using a tub, shower or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub, or shower, reaching head and body parts for soaping, rinsing, and drying. Grooming includes hair combing and brushing, shampooing, oral hygiene, shaving and fingernail and toenail care.

(3) Dressing includes putting on and taking off, fastening and unfastening garments and undergarments, and special devices such as back or leg braces, corsets, elastic stockings/garments and artificial limbs or splints.

(4) Bowel, bladder and menstrual care including assisting the person on and off toilet or commode and emptying commode, managing clothing and wiping and cleaning body after toileting, assistance with using and emptying bedpans, ostomy and/or catheter receptacles and urinals, application of diapers and disposable barrier pads.

HANDBOOK CONTINUES

30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY 30-780
(Continued)

HANDBOOK CONTINUES

(5) Repositioning, transfer, skin care, and range of motion exercises.

(A) Includes moving from one sitting or lying position to another sitting or lying position; e.g., from bed to or from a wheelchair, chair, or sofa, and the like, coming to a standing position and/or rubbing skin and repositioning to promote circulation and prevent skin breakdown. However, if decubiti have developed, the need for skin and wound care is a paramedical service.

(B) Such exercises shall include the carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function, improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities; and assistive walking.

(6) Feeding, hydration assistance including reaching for, picking up, grasping utensil and cup; getting food on utensil, bringing food, utensil, cup to mouth, manipulating food on plate. Cleaning face and hands as necessary following meal.

(7) Assistance with self-administration of medications. Assistance with self-administration of medications consists of reminding the beneficiary to take prescribed and/or over-the-counter medications when they are to be taken and setting up Medi-sets.

(8) Respiration limited to nonmedical services such as assistance with self-administration of oxygen, assistance in the use of a nebulizer, and cleaning oxygen equipment.

(9) Paramedical services are defined in Welfare and Institutions Code Section 12300.1 as follows:

(A) Paramedical services include the administration of medications, puncturing the skin or inserting a medical device into a body orifice, activities requiring sterile procedures, or other activities requiring judgment based on training given by a licensed health care professional.

HANDBOOK CONTINUES

30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY 30-780
(Continued)

HANDBOOK CONTINUES

(B) Paramedical services are activities which persons could perform for themselves but for their functional limitations.

(C) Paramedical services are activities which, due to the beneficiary's physical or mental condition, are necessary to maintain the beneficiary's health.

(b) Ancillary services are subject to time per task guidelines when established in Sections 30-758 and 30-763.235(b) and 30-763.24 of the Department of Social Services' Manual of Policies and Procedures and are limited to the following:

(1) Domestic services are limited to the following:

(A) Sweeping, vacuuming, washing and waxing of floor surfaces.

(B) Washing kitchen counters and sinks.

(C) Storing food and supplies.

(D) Taking out the garbage.

(E) Dusting and picking up.

(F) Cleaning oven and stove.

(G) Cleaning and defrosting refrigerator.

(H) Bringing in fuel for heating or cooking purposes from a fuel bin in the yard.

(I) Changing bed linen.

(J) Miscellaneous domestic services (e.g., changing light bulbs and wheelchair cleaning, and changing and recharging wheelchair batteries) when the service is identified and documented by the case worker as necessary for the beneficiary to remain safely in his/her home.

HANDBOOK CONTINUES

30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY 30-780
(Continued)

HANDBOOK CONTINUES

(2) Laundry services include washing and drying laundry, and is limited to sorting, manipulating soap containers, reaching into machines, handling wet laundry, operating machine controls, hanging laundry to dry if dryer is not routinely used, mending, or ironing, folding, and storing clothing on shelves, in closets or in drawers.

(3) Reasonable food shopping and errands limited to the nearest available stores or other facilities consistent with the beneficiary's economy and needs; compiling a list, bending, reaching, and lifting, managing cart or basket, identifying items needed, putting items away, phoning in and picking up prescriptions, and buying clothing.

(4) Meal preparation and cleanup including planning menus; e.g., washing, peeling and slicing vegetables; opening packages, cans and bags, mixing ingredients; lifting pots and pans; reheating food, cooking and safely operating stove, setting the table and serving the meals; cutting the food into bite-size pieces; washing and drying dishes, and putting them away.

(5) Assistance by the provider is available for accompaniment when the beneficiary's presence is required at the destination and such assistance is necessary to accomplish the travel limited to:

(A) Accompaniment to and from appointments with physicians, dentists and other health practitioners. This accompaniment shall be authorized only after staff of the designated county department has determined that no other Medi-Cal service will provide transportation in the specific case.

(B) Accompaniment to the site where alternative resources provide in-home supportive services to the beneficiary in lieu of IHSS. This accompaniment shall be authorized only after staff of the designated county department have determined that neither accompaniment nor transportation is available by the program.

HANDBOOK CONTINUES

30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY 30-780
(Continued)

HANDBOOK CONTINUES

(6) Heavy Cleaning which involves thorough cleaning of the home to remove hazardous debris or dirt.

(7) Yard hazard abatement which is light work in the yard which may be authorized for:

(A) removal of high grass or weeds and rubbish when this constitutes a fire hazard.

(B) removal of ice, snow or other hazardous substances from entrances and essential walkways when access to the home is hazardous.

(c) Ancillary services may not be provided separately from personal care services listed in subsection (a) above.

.2 Personal Care Services Program Tasks

DHS regulation Section 51350 reads:

Personal Care Services.

(a) Personal care services as specified in Section 51183 are provided when authorized by the staff of a designated county department based on the state approved Uniformity Assessment tool. To the extent not inconsistent with statutes and regulations governing the Medi-Cal program, the needs assessment process shall be governed by the Department of Social Services' Manual of Policies and Procedures Sections 30-760, 30-761, and 30-763.

(b) Personal care services may be provided only to a categorically needy beneficiary as defined in Welfare and Institutions Code, Section 14050.1, who has a chronic, disabling condition that causes functional impairment that is expected to last at least 12 consecutive months or that is expected to result in death within 12 months and who is unable to remain safely at home without the services. The services shall be provided in the beneficiary's home or other locations as may be authorized by the Director subject to federal approval. Personal care services authorized shall not exceed 283 hours in a calendar month.

HANDBOOK CONTINUES

30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY 30-780
(Continued)

HANDBOOK CONTINUES

(c) Personal care services will be prescribed by a physician. The beneficiary's medical necessity for personal care shall be certified by a licensed physician. Physician certification shall be done annually.

(d) Registered nurse supervision consists of review of the service plan and provision of supportive intervention. The nurse shall review each case record at least every twelve months. The nurse shall make home visits to evaluate the beneficiary's condition and the effectiveness of personal care services based on review of the case record or whenever determined as necessary by staff of a designated county department. If appropriate, the nurse shall arrange for medical follow-up. All nurse supervision activities shall be documented and signed in the case record of the beneficiary.

(e) Paramedical services when included in the personal care plan of treatment must be ordered by a licensed health professional lawfully authorized by the State. The order shall include a statement of informed consent saying that the beneficiary has been informed of the potential risks arising from receipt of such services. The statement of informed consent shall be signed and dated by the beneficiary, the personal representative of the beneficiary, or in the case of a minor, the legal parent or guardian.

(f) Grooming shall exclude cutting with scissors or clipping toenails.

(g) Menstrual care is limited to external application of sanitary napkin and cleaning. Catheter insertion, ostomy irrigation and bowel program are not bowel or bladder care but paramedical.

(h) Repositioning, transfer skin care, and range of motion exercises have the following limitations:

(1) Includes moving from one sitting or lying position to another sitting or lying position; e.g., from bed to or from a wheelchair, or sofa, coming to a standing position and/or rubbing skin and repositioning to promote circulation and prevent skin breakdown. However, if decubiti have developed, the need for skin and wound care is a paramedical service.

HANDBOOK CONTINUES

30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY 30-780
(Continued)

HANDBOOK CONTINUES

(2) Range of motion exercises shall be limited to the general supervision of exercises which have been taught to the beneficiary by a licensed therapist or other health care professional to restore mobility restricted because of the injury, disuse or disease. Range of motion exercises shall be limited to maintenance therapy when the specialized knowledge or judgment of a qualified therapist is not required and the exercises are consistent with the beneficiary's capacity and tolerance. Such exercises shall include the carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function, improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities; and assistive walking.

.3 Personal Care Services Program Required Documentation

DHS regulation Section 51476.2 reads:

Personal Care Services Records.

Each county shall keep, maintain, and have readily retrievable, such records as are necessary to fully disclose the type and extent of personal care services provided to a Medi-Cal beneficiary. Records shall be made at or near the time the service is rendered or the assessment or other activity is performed. Such records shall include, but not be limited to the following:

(a) Time sheets

(b) Assessment forms and notes

(c) All service records, care plans, and orders/prescriptions ordering personal care.

HANDBOOK ENDS HERE

30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY **30-780**
(Continued)

.4 Eligibility for PCSP shall be limited to those IHSS recipients who do not receive IHSS advance payment as specified in Section 30-769.731.

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Section 14132.95, Welfare and Institutions Code; and the State Plan Amendment, approved pursuant to Section 14132.95(b), Welfare and Institutions Code.

Day 2 Map/Notes

IHSS Training Academy

Day 2 - Authorizing Services

- Welcome / Introductions
  - Housekeeping
  - Parking Lot
  - Overview of Day /Expectations

- Authorizing Services
  - Shared Living
  - Exercise: Exceptions to shared living
  - Time Limited Authorizations

- Removing Services

- Documentation

- Authorizing Services –Emily and Joe One Year Later

- Avoiding Authorization Errors
  - Data
  - Hot Spots to Watch

- END OF DAY 2: Post Assessment

- Exercise and Overview of 2 days

- Wrap up, Comments, Evaluations

IHSS Training Academy

Day 2: Authorizing Services

When Authorizing Services

- IHSS operates under a "safety" standard, not a "comfort" standard.
- MPP 30-761.25 states: *"no services shall be determined to be needed which the consumer is able to perform in a safe manner without an unreasonable amount of physical or emotional stress."*

Authorizing Services

- Consider functional rankings first.
- Break service up into components.
- Ask about the frequency and duration of each task.
- Consult existing regulatory guidelines
- Document exceptions
- Think critically – "What is the need?"
- Consider "good days" and "bad days".
- Consider that at reassessment, functional rankings may change.

Time Per Task

- Converting functional assessment into authorization of tasks
- Future release of regulatory Time Per Task Guidelines

Existing Regulatory Guidelines

Domestic [MPP 30-758.11]
- 6 hours/month

Laundry [MPP 30-758.121 & 30-758.122]
- Laundry facilities on the premises: 1.0 hour/week
- Laundry facilities not on the premises: 1.5 hours/week

Shopping for Food [MPP 30-758.13]
- 1.0 hour/week
- Not on IHSS Meal Allowance or SSP Meal Allowance [MPP 30-757.134(a)]

Other Shopping and Errands [MPP 30-758.14]
- 0.5 hour/week

Shared Living

- Consumer resides in the same living unit with one or more persons.

"Own Home"

For IHSS purposes, an individual's own home is the place in which that individual chooses to reside except an acute care hospital, skilled nursing facility, intermediate care facility, community care facility, or board and care facility [MPP 30-701(o)], even if she/he choose to live there.

Shared Living is *NOT*…

- Living only with Able and Available Spouse: those policies take precedence.
- Landlord who provides care and supervision- could be Board and Care arrangement.
- Board and Care facilities, Residential Care facilities, Skilled Nursing facilities, Intermediate Care facilities, and Community Care facilities. These are considered NOT Living in "Own Home".

Shared Living

- Some IHSS services must be prorated when recipient is in a shared living arrangement. These services are:
  - Domestic
  - Laundry
  - Meal Preparation and Clean-up
  - Shopping for Food, Errands
  - Heavy Cleaning, Yard Hazard Abatement
  - Protective Supervision, Teaching & Demo.

Proration

Proration is the process of determining the individual need for the consumer after making adjustments for living arrangements, from the total need of the household.

Proration of Domestic

When prorating consider:

- Rooms/areas used in common
- Rooms/areas used solely by consumer
- Rooms/areas used solely by others

Proration of Related

When prorating consider:

- Needs met in common
- Needs met solely for consumer
- Needs met solely for others

Documentation: SOC293

- For all services that are prorated, the **"Total Need"** column of SOC293 means the total number of hours needed by *the entire household*, before any adjustments are made.
- For all services that are prorated, the **"Adjustments"** column of the SOC293 means the total number of hours needed by *household members other than the consumer*.

Exercise: Exceptions to Shared Living

- Apply State Regulations to your Scenario.
- On Flip Chart:
  - Record type of exception.
  - Create a diagram to show how each room is considered in the proration.
- Report out to entire group –sharing case, your decision and regulations used.

Time Limited Authorizations

- When assessment is initially done SW should decide if the consumer's condition will change within in the 12-month time period.
- If condition warrants a more frequent time frame, the case plan should identify a shorter reassessment time period.

Removing Services

- Consider progression of dementia may lessen need. Reassess needs yearly – should they be assessed more often?
- Authorization should change when the consumer deteriorates and is no longer capable of putting self at risk.
- Consider family stress and refer to alternative resources.
- Document clearly for possible consumer challenge of decision.

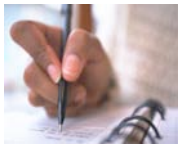
Exceptions *must be documented in a way that clarifies for the reader what the need is, and why more or less time is necessary for both safety and maintenance of independence.*

Importance of Good Documentation

- Creates a visual picture of the SW visit.
- Provides historical record important to coverage when you're not in the field.
- Provides continuity for case transfers and inter-county transfers.
- Substantiates authorization at State Hearings.
- Adherence to federal and state laws, regulations and policies.
- Aids in the investigation of potential fraud.

Documentation : Additional Considerations

- Create a clear picture of the situation.
- Avoid documenting unnecessary information.
- Record the facts and avoid judging statements.
- Keep to the point and purpose of the visit.
- The files are open - all information may be read by the consumer.
- Don't document mental illness diagnosis unless it has been confirmed.



Exercise

Authorizing Services

Joe & *Emily* one Year later…

Joe and *Emily one year later …*

- ***Part 1:***
  - *Review new Scenario*
  - *Utilize Day 1 Narrative documentation and Assessment worksheet to familiarize with the original scenario.*
  - *Reassess FI scores and H line documentation for appropriateness*
  - *Report out:*
    - *Any changes in FI scores –use Annotated Assessment Criteria as resource for making decisions*
    - *How helpful was their documentation from Day 1?*
    - *What would you need to document after reassessment / reauthorization?*

Joe and Emily one year later …

- ***Part 2:***
  - *Using grid side of SOC293 categories identify questions you would need to ask to clarify reauthorization of services?*
  - *What are the critical pieces of information you will need to make service hour determinations in each category?*
  - *Report out to entire group.*

Exercise: Authorization Hot Spots

On the flip charts posted around the room record what they think a common problem is with authorization of services in each of these areas.

General Hot Spots to Watch

- Authorization of services that consumers can independently perform.
- Services authorized or extra time for services authorized to meet consumer desires and preferences.
- Services authorized when consumer experience some difficulty performing task, however it does not put them at risk for injury, hazard or accident.
- Assessment of needs when assistive device allows consumer independence.

Data for Training Academy

- Analysis of statewide CMIPS data focused on "Total Need," before adjusting (prorating) for shared living arrangements and before taking into consideration alternative resources or refused services.
  - The reason this column was used is that it is the area where the Social Worker has the most discretion.
  - The Adjustment column is most dependent on the demographics of the county and the consumer's living arrangement.
  - The Alternative Resource column is most dependent on the county's long term care resources.

Data for Training Academy

- When H line Functional Ranking was compared to hours of Total Need, the only cases used in this comparison were those who were brand new to IHSS and had not had an IHSS reassessment of need.

Hot Spots to Watch

AA Domestic Services

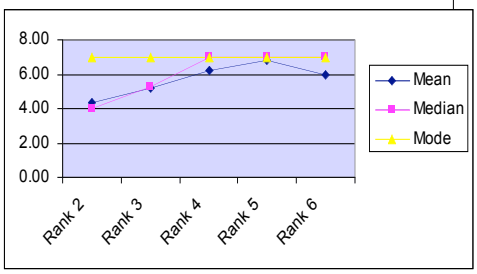
- *Everyone is assessed 6.00 hours per month regardless of FI score.*
- *Size of residence or lifestyle choice is not taken into consideration.*
- *Able/Available spouse or is a minor child with parent provider - The total need is divided by the number living in the household without taking into consideration shared living situations.*
- *Social workers are sometimes not familiar how to document "refused services".*

Hot Spots to Watch

BB & CC Meal preparation and Clean-up

- *Needs are assessed for meals that consumers are able to prepare/clean up without any assistance.*
- *Consumers are assessed the same amount of time regardless of what type of meals they eat (frozen dinner vs. full meal).*
- *Everyone gets the same amount of time for meal prep/clean up regardless of what they eat or their FI score.*

Meal Preparation



Mean is the arithmetic average
Median is the midpoint when listing all values in ascending order
Mode is the most common value

Example of Statewide Trends

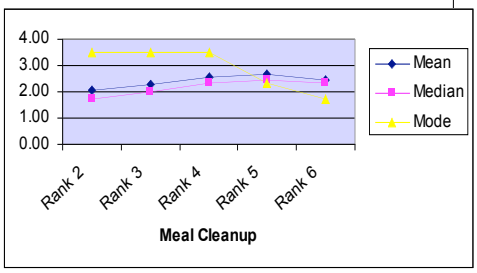
Meal Preparation

- CMIPS data shows that, excluding Protective Supervision, the most number of hours of IHSS are going to Meal Preparation (more than a quarter of the hours).
- It's unusual to be granted IHSS without Meal Preparation (95% of all IHSS consumers in the State are authorized this task).
- Regardless of the functional ranking, almost all consumers have the need for 7 hours a week.

Meal Preparation

- 3 of every 5 consumers have a Total Need of 7 hours per week, regardless of the number of meals the consumer needs assistance with.
- Statewide, 92.7% of all “new” consumers are determined to have a Total Need for Meal Preparation.

Meal Cleanup



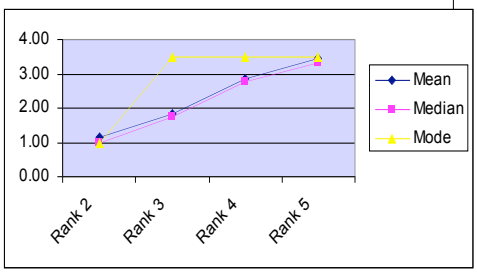
Mean is the arithmetic average
Median is the midpoint when listing all values in ascending order
Mode is the most common value

Hot Spots to Watch

PP Bathing, Oral Hygiene, Grooming

- *A need is assessed for services that consumer is able to perform without assistance.*
- *Services are assessed daily and it is apparent that they are not being performed (consumer is not clean).*

Bathing, Oral Hygiene and Grooming



Mean is the arithmetic average
Median is the midpoint when listing all values in ascending order
Mode is the most common value

Bathing, Oral Hygiene and Grooming

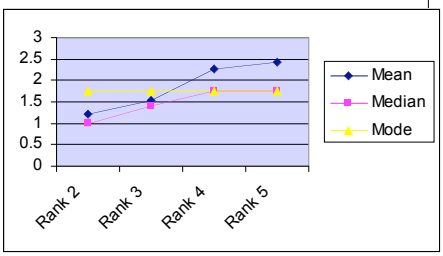
- Bathing is the most common personal care task authorized.
- Clients are most often given 3.5 hours per week, regardless of their functioning.
- That's usually a half hour a day, seven days a week.
  - Many clients don't get 7 day a week care.
  - Many older clients don't bathe daily unless they are incontinent.

Hot Spots to Watch

NN Ambulation

- *A need is assessed for assistance moving around outside of the home – time should be related to daily activities which the consumer needs to walk (or use a wheelchair/walker) to perform, such as walking to and from the bathroom, bedroom and kitchen.*
- *Ambulation is not authorized for general exercise purposes or for assistance walking outside of the home.*
- *Need is often based solely on the fact that the consumer uses an assistive device - just the fact that the consumer uses an assistive device; they should not automatically be assessed time for ambulation.*

Ambulation



Mean is the arithmetic average
Median is the midpoint when listing all values in ascending order
Mode is the most common value

Ambulation

- Regardless of functional ranking, the most common authorization for ambulation is 15 minutes a day, 7 days a week.

Hot Spots to Watch

MM Menstrual Care

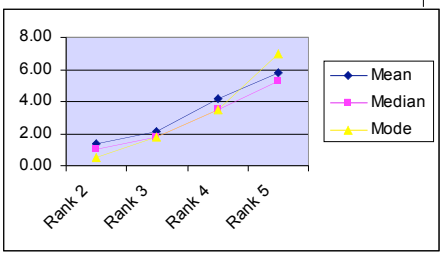
- *A need is assessed when the consumer is able to perform the task without assistance.*
- *Need is typically monthly, however assessed need does not reflect it as such - menstrual cycles are normally only once a month, however time is sometimes assessed as a weekly need.*

Hot Spots to Watch

Bowel and Bladder Assistance

- *Service is assessed when the consumer experiences some difficulty performing a task, however it does not put them at risk for injury, hazard or accident.*
- *A need is assessed for consumers who wear diapers but are able to manage without assistance from another.*

Bowel and Bladder Assistance



Mean is the arithmetic average
Median is the midpoint when listing all values in ascending order
Mode is the most common value

Bowel and Bladder

- The mean, median and mode all increase as the functional ranking increases.
- Staff tend to authorize 15 minute a day for a rank of 3; 30 minutes a day for a rank of 4; 45 minutes a day for a rank of 5.

Bowel and Bladder

- Only 10% of all new cases have an assessed need for Bowel and Bladder care vs. 49% of all consumers. This is such a large difference, it is unlikely that consumers are authorized the assistance they need with toileting.
- For a consumer to be forthcoming with information about his/her toileting habits, needs and impairments, Social Workers must not be embarrassed by the subject and must be able to put the applicant at ease in discussing this task.

Post Assessment Evaluation

PUZZLE EXERCISE


End of Day 2
Thanks for Your Participation!

Shared Living Arrangements

Able and Available Spouse

- When an IHSS consumer has a spouse who does not receive IHSS, the spouse shall be presumed able to perform certain specified tasks unless he/she provides medical verification of his/her inability to do so.

- An able spouse of an IHSS consumer shall be presumed available to perform certain specified tasks except during those times he/she is out of the home for employment, health or for other unavoidable reasons and the service must be provided during his/her absence.

- When the consumer has an Able and Available spouse there shall be no payment to the spouse or any other provider for the following services:
  - Domestic
  - Related services
  - Yard hazard abatement
  - Teaching and demonstration
  - Heavy cleaning

- When an able spouse is not available because of employment, health, or other unavoidable reasons, a provider may be paid for the following services only if they must be provided during the spouse's absence:
  - Meal preparation
  - Transportation
  - Protective Supervision

- An able and available spouse or other provider may be paid for providing:
  - Personal care services
  - Paramedical service

- In addition (to those service listed in Section 30-763.445) –a spouse may be paid to provide the following services when he/she leaves full-time employment or wishes to seek employment but is prevented form doing so because no other suitable provider is available
  - Transportation
  - Protective supervision

- Documentation: SOC 293

	Total Need	Adjustments	Individual Assessed Need	Alternative Resources	Auth to be purchased
Domestic services	6.00		6.00	6.00	
Meal Preparation	5.00		5.00	5.00	
Meal Clean up	3.00		3.00	3.00	
Routine Laundry	1.00		1.00	1.00	
Shopping for Food	1.00		1.00	1.00	
Other shopping and errands	.50		.50	0.50	

No adjustments are made in the adjustments column on the SOC 293 for Domestic and Related services. Instead, they are zeroed out in the Alternative Resources column.

CDSS Regulations

Shared Living Arrangements

Shared Living Arrangements: The following steps apply to assessing need for consumers who live with another person(s). With certain exceptions specified in Section 30-763.4 (Able and Available Spouse), the need for IHSS shall be determined in the following manner.

Domestic Services and Heavy Cleaning

- The living area in the house shall be divided into areas used solely by the consumer, areas used in common with others, and areas not used by the consumer.
- No need shall be assessed for areas not used by the consumer.
- The need for services in common living areas shall be prorated to all the housemates, the consumer's need being his/her prorated share.
- For areas used solely by the consumer, the assessment shall be based on the consumer's individual need.

Related Services need shall be assessed as follows:

- When the need is being met in common with those of other housemates, the need shall be prorated to all the housemates involved, and the consumer's need is his/her prorated share.
- When the service is not being provided by a housemate, and is being provided separately to the consumer, the assessment shall be based on he consumer's individual need.

The need for protective supervision shall be assessed based on the consumer's individual need provided that:

- When two (or more) IHSS consumers are living together and both require protective supervision, the need shall be treated as a common need and prorated accordingly. In the event that proration results in one consumer's assessed need exceeding the payment and hourly maximums provided in Section 30-765, the apportionment of need shall be adjusted between the consumer so that all, or as much as possible of the total common need for protective supervision may be met within the payment and hourly maximums.
- For service authorization purposes, no need for protective supervision exists during periods when a provider is in the home to provide other services.

The need for teaching and demonstration services shall be assessed based on the consumer's individual need, except when consumer live together and have a common need, the need shall be met in common when feasible.

Other IHSS Services:

- The consumer's need for transportation services, paramedical services, and personal care services shall be assessed based on the consumer's individual need.
- The need for yard hazard abatement shall not be assessed in shared living arrangements, except when all housemates fall into one or more of the following categories:
    - Other IHSS consumer unable to provide such services.
    - Other persons physically or mentally unable to provide such services.
    - Children under the age of fourteen years.

CDSS Regulations

Shared Living Arrangements: Exceptions

Landlord / Tenant Arrangements

- When the consumer is the tenant, the need for domestic and heavy cleaning services shall be based on the living area used solely by the consumer. No need for yard hazard abatement shall be assessed. The needs assessment shall take into account any services the landlord is obligated to perform under the rental agreement.

- When the consumer is the landlord, the need for domestic and heavy cleaning services shall be assessed for all living areas not used solely by the tenant. The needs assessments shall take into account any services the tenant is obligated to perform under the rental agreement.

If the consumer has moved into a relative's home primarily for the purpose of receiving services, the need for domestic and heavy cleaning services shall be assessed only for living areas used solely by the consumer. Yard hazard abatement services shall not be provided.

When the consumer is a parent living with his/her child(ren) who is under fourteen years of age and who is not eligible or does not need IHSS.

- The consumer's need for domestic and heavy cleaning services in common living areas and for related services shall be assessed as if the child(ren) did not live in the home
- The child(ren)'s needs shall not be considered when assessing the need for services, including domestic or heavy cleaning in areas used solely by the child(ren).

Live-In Providers:

- Domestic and heavy cleaning services shall not be provided in areas used solely by the provider. The need for related services may be prorated between the provider and the consumer, if the provider and the consumer agree. All other services shall be assessed based on the consumer's individual need, except as provided in sections 30-673.33 /.34.

Example: Adult Consumer
Living with Grandchildren

August shares her two-bedroom apartment with her two grandchildren, ages 5 and 10. She has sole use of one bedroom and the grandchildren share the other bedroom. In addition to the bedrooms, there is one bathroom, kitchen, living room, and dining room, which are used in common. August needs help with Domestic, Meal Preparation, Laundry, Shopping, and some Personal Care services.

Domestic and Related services on August's SOC-293 will look like this:

	Total Need	Adjustments	Individual Assessed Need	Alternative Resource	Auth To Be Purch	Unmet Need	County Use
Domestic Services	5.00[1]	2.67[2]	1.33		1.33		
Preparation of Meals	7.00	4.66	2.33		2.33		
Meal Clean Up	3.50	2.33	1.17		1.17		
Routine Laundry, Etc.	1.00	.67	.33		.33		
Shopping for Food	1.00	.67	.33		.33		
Other Shopping & Errands	.50	.34	.16		.16		
Heavy Cleaning							
Remove Snow, Ice							
Remove Grass Weeds, Rubbish							
Protective Supervision							

[1] Household need was assessed as 1.0 hour for each of six rooms. One hour was subtracted for the hour used solely by the grandchildren.
[2] Adjustments reflect the grandchildren's share of the rooms used in common (4:00 / 3 = 1.33).

Example: Consumer Moves In With Relative To Receive Services

Stanley moves in with his family to receive IHSS services. Stanley has sole use of one bedroom and one bathroom. Other family members in the house are his son John, daughter-in-law, and ten-year old grandson.

Stanley needs help with Domestic, Meal Preparation, Laundry, Shopping, and some Personal Care services. He is incontinent and requires some extra bed linen changes and laundry because of this. His laundry is done separately from the rest of the family.

Domestic and Related services on Andy's SOC-293 will look like this:

	Total Need	Adjustments	Individual Assessed Need	Alternative Resource	Auth To Be Purch	Unmet Need	County Use
Domestic Services	2.50		2.50		2.50		
Preparation of Meals	7.00	5.25	1.75		1.75		
Meal Clean Up	3.50	2.62	.88		.88		
Routine Laundry, Etc.	1.50		1.50		1.50		
Shopping for Food	1.00	.75	.25		.25		
Other Shopping & Errands	.50	.37	.13		.13		
Heavy Cleaning							
Remove Snow, Ice							
Remove Grass Weeds, Rubbish							
Protective Supervision							

Example: Live-In Provider

Steven and is family decide it is no longer safe for him to live alone. Steven asks his provider to move in with him and Isaac agrees. There are two bedrooms, one bathroom, living room, kitchen, and dining room. When asked by the social worker whether he will agree to allow proration of related services, Steven declines. Steven needs help with Domestic, Meal Preparation, Laundry, Shopping, and some Personal Care services.

Domestic and Related services on Steven's SOC-293 will look like this:

	Total Need	Adjustments	Individual Assessed Need	Alternative Resource	Auth To Be Purch	Unmet Need	County Use
Domestic Services	5.00[1]	2.00[2]	3.00		3.00		
Preparation of Meals	7.00		7.00		7.00		
Meal Clean Up	3.50		3.50		3.50		
Routine Laundry, Etc	1.00		1.00		1.00		
Shopping for Food	1.00		1.00		1.00		
Other Shopping & Errands	.50		.50		.50		
Heavy Cleaning							
Remove Snow, Ice							
Remove Grass Weeds, Rubbish							
Protective Supervision							

[1] The total household need for Domestic was determined to be 6.0 hours (1.0 hour per room). One hour was subtracted for the time necessary to clean the provider's room.

[2] Adjustments were for the provider's share of rooms used in common, which are used equally by recipient and provider.

Example: Able/Available Spouse

Patrick lives with his Able and Available spouse Kathy in a two-bedroom house. The house also contains a living room, kitchen, and bathroom. Patrick requires Domestic and Related services as well as Personal Care.

Domestic and Related services on Patrick's SOC-293 will look like this:

	Total Need	Adjustments	Individual Assessed Need	Alternative Resource	Auth To Be Purch	Unmet Need	County Use
Domestic Services	5.00[1]		5.00	5.00			
Preparation of Meals	7.00		7.00	7.00			
Meal Clean Up	3.50		3.50	3.50			
Routine Laundry, Etc.	1.00		1.00	1.00			
Shopping for Food	1.00		1.00	1.00			
Other Shopping & Errands	0.50		0.50	0.50			
Heavy Cleaning							
Remove Snow, Ice							
Remove Grass Weeds, Rubbish							
Protective Supervision							

[1] House has five rooms. Social worker assessed 1.0 hour per month for each room.

Example: Able/Available Spouse
(Spouse Unavailable Because of Employment)

Ed lives with his able spouse Rebecca in a two-bedroom house. The house also contains a living room, kitchen, and bathroom. Ed requires Domestic and Related services as well as Personal Care. Rebecca is employed full-time. She leaves home at 7:00 am after fixing Ed his breakfast and returns at 6:00 p.m. He is unsteady on his feet and has no stamina to stand and fix or reheat his lunch. A provider (not Rebecca) comes five days per week and fixes his lunch and provides personal care.

Domestic and Related services on Ed's SOC-293 will look like this:

	Total Need	Adjustments	Individual Assessed Need	Alternative Resource	Auth To Be Purch	Unmet Need	County Use
Domestic Services	5.00[1]	2.50	2.50	2.50			
Preparation of Meals	7.00	3.50	3.50	2.25	1.25		
Meal Clean Up	3.50	1.75	1.75	1.75			
Routine Laundry, Etc	1.00	0.50	0.50	0.50			
Shopping for Food	1.00	0.50	0.50	0.50			
Other Shopping & Errands	0.50	0.25	0.25	0.25			
Heavy Cleaning							
Remove Snow, Ice							
Remove Grass Weeds, Rubbish							
Protective Supervision							

[1] House has five rooms. Social Worker assessed 1.0 hour per month for each room.

Example: Landlord/Tenant Arrangement

Peter decides to rent a room from Larry (his housemate/landlord). Peter signs a rental agreement stating that he will pay Larry $400 per month rent in exchange for exclusive use of one bedroom, one bathroom, and shared use of the kitchen and dining room. The rental agreement provides that Larry will clean Peter's bathroom. Peter will hire his sister as his IHSS provider. She will clean his bedroom, do his laundry, meal preparation and clean-up, and shopping. Peter needs help with Domestic, Meal Preparation and Cleanup, Laundry, and Shopping.

Domestic and Related Services on Peter's SOC-293 will look like this:

	Total Need	Adjustments	Individual Assessed Need	Alternative Resource	Auth To Be Purch	Unmet Need	County Use
Domestic Services	2.00		2.00	1.50	0.50		
Preparation of Meals	7.00		7.00		7.00		
Meal Clean Up	3.50		3.50		3.50		
Routine Laundry, Etc.	1.00		1.00		1.00		
Shopping for Food	1.00		1.00		1.00		
Other Shopping & Errands	0.50		0.50		0.50		
Heavy Cleaning							
Remove Snow, Ice							
Remove Grass Weeds, Rubbish							
Protective Supervision							

Example: Adult Consumer
Living With Own Children

Denise shares her two-bedroom apartment with her ex-husband from whom she is recently divorced. Denise has sole use of one bedroom and the children share the other bedroom. In addition to the bedrooms, there is one bathroom, kitchen, living room, and dining room, which are used in common. Denise needs help with Domestic, Meal Preparation, Laundry, Shopping, and some Personal Care services.

Domestic and Related services on Denise's SOC-293 will look like this:

	Total Need	Adjustments	Individual Assessed Need	Alternative Resource	Auth To Be Purch	Unmet Need	County Use
Domestic Services	5.00[1]		5.00		5.00		
Preparation of Meals	7.00		7.00		7.00		
Meal Clean Up	3.50		3.50		3.50		
Routine Laundry, Etc	1.00		1.00		1.00		
Shopping for Food	1.00		1.00		1.00		
Other Shopping & Errands	0.50		0.50		0.50		
Heavy Cleaning							
Remove Snow, Ice							
Remove Grass Weeds, Rubbish							
Protective Supervision							

[1] Household need was assessed as 1.0 hour for each of six rooms. One hour was subtracted for the hour used solely by the children.

Alternative Resources

Alternative Resources to Consider

Adult Day Care offers non-medical services to adults 60 and older who are in need of some supervision and assistance. Day care activities are held at senior centers and include music, exercise, arts and crafts, discussion groups and outings. Some centers provide transportations, if necessary.

Adult Protective Services (APS) services adults 65 and older as well as disabled adults 18 to 65 who are harmed or threatened with harm. APS investigates cases of neglect, abandonment, and physical, fiduciary or sexual abuse. After a report of suspected abuse comes into the Call Center (800) 510-2020, an assessment is made, by a social worker, and recommendations are made as to how the situation can be improved. Coordination with law enforcement begins as soon as criminal abuse is identified. Referrals to other programs often follow, along with emergency provisions of food, shelter or in-home aid. *(These may be considered alternative resources if any personal care services are provided by these referrals).*

AIS Call Center has one easy phone number - (800) 510-2020 - that is the gateway for information and assistance. This is also the number to report elder or dependent adult abuse, or to apply for a variety of services for older adults, persons with disabilities and their families.

Alzheimer's Day Centers give respite to family caregivers assisting persons with Alzheimer's disease. These specialized day programs provide valuable interaction for seniors with Alzheimer's disease and related memory problems.'

Brown Bag Program delivers surplus food items each month to low-income adults age 60 and older, helping to supplement their food budgets. Food is gleaned by volunteers (mostly seniors themselves) and donated by farmers, warehouses, packing companies and retail food chains.

Family Caregiver Support Program targets the needs of those who care for a family member. Services include support groups, respite, counseling and help with identifying resources. *(Can be considered as Alternative Resource as long as PCSP is provided; i.e. grooming, bathroom, feeding, changing diapers, etc.)*

Home-Delivered Meals are offered to adults 60 and older who are homebound due to illness or disability, who ask to have meals delivered to them. A social worker will visit to assess the need. If appropriate for the program, a hot meal is delivered each weekday and frozen meals are provided for the weekends. The cost is a voluntary donation.

Linkages serves functionally impaired and disabled adults age 18 and older, who are at risk of nursing home or board and care placement and ineligible for other care management programs.

Multipurpose Senior Services Program (MSSP) is for seniors age 65 and above who are eligible for Medi-Cal and at risk of nursing home placement. Care management services are provided to help clients – many with medical problems – to live safely in the community.

Nutrition Centers provide hot, nutritious lunches during the week, for adults age 60 and older. Besides promoting better nutrition, these centers reduce the isolation of many older adults who may live alone.

Ombudsman Program provides advocates for residents in long-term care facilities. These advocates maintain a presence in the facilities; respond to, and resolve complaints; act as mediators; support residents rights; and witness certain legal documents. Visits by Ombudsmen are unannounced, and all discussions with residents are confidential.

Project CARE is a community network program that provides an early warning of distress for frail, ill or disabled persons living at home. Services include daily "Are you OK?" phone checks, Postal Alert, Gatekeeper, minor home repairs and more.

California Home Thursday, June 30, 2005

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CALIFORNIA DEPARTMENT OF AGING

Services and Programs

Adult Day Health Care (ADHC) - A day care program which provides health, therapeutic, and social services to serve the specialized needs of frail elderly as well as adults with functional impairments at risk of institutionalization.

Alzheimer's Day Care Resource Centers (ADCRC) - Day care for persons with Alzheimer's disease (and other related dementias) who are often unable to be served by other programs. The centers provide respite as well as training and support for families and professional caregivers.

Area Agencies on Aging - The Area Agencies on Aging coordinate a wide array of services to seniors and adults with disabilities at the community level and serve as a focal point for local aging concerns.

Brown Bag Program - Volunteers collect and distribute surplus food to low-income seniors.

California Long-Term Care Ombudsman Program - Professional staff and trained volunteers investigate and resolve complaints made by or on behalf of residents of long term care facilities.

Foster Grandparent Program - Low-income senior volunteers work with children who have exceptional needs.

Health Insurance Counseling and Advocacy Program (HICAP) - Provides both community education sessions open to the public and individualized one-to-one counseling on Medicare, managed care, and other private health insurance issues.

Information & Assistance - Trained staff provide information as well as assistance and follow-up to link seniors and adults with functional impairments and their families with programs and services in their community.

Legal Assistance - Community programs provide legal information, advice, and counseling, as well as administrative and judicial representation for seniors.

Linkages - Case management services to elderly as well as adults with functional impairments, 18 years or older, at risk of institutionalization. Clients do not need to be eligible for Medi-Cal.

Multipurpose Senior Services Program (MSSP) - Provides social and health case management to assist persons aged 65 and over, eligible for Medi-Cal and certifiable for skilled nursing care, to remain safely at home.

Search
My CA

Californians, for information on services in your area for seniors or adults with disabilities, call toll-free:

1-800-510-2020

Outside California, call the toll-free Eldercare Locator service at 1-800-677-1116

Related Links

- Adult Day Health Care (ADHC)
- Alzheimer's Day Care Resource Centers (ADCRC)
- Area Agencies on Aging
- Brown Bag Program
- California Long-Term Care Ombudsman
- Foster Grandparent Program
- Health Insurance Counseling and Advocacy Program (HICAP)
- Information & Assistance
- Legal Assistance
- Linkages
- Multipurpose Senior Services Program (MSSP)
- Nutrition Services

Nutrition Services - *Congregate Meals:* local programs provide seniors with nutritious meals in a group setting; *Home Delivered Meals:* local programs prepare and deliver nutritious meals to homebound seniors.

Respite Program - Provides temporary or periodic services for frail elderly or adults with functional impairments to relieve persons who are providing care, or recruiting and screening of providers and matching respite providers to clients.

Senior Community Service Employment Program (SCSEP) - Provides part-time subsidized employment for low-income persons over age 55.

Senior Companion Program - Low-income senior volunteers provide peer support to frail older persons in their local communities.

- Respite Program
- Senior Community Service Employment Program (SCSEP)
- Senior Companion Program

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Authorization Hot Spots

Authorization of Services:
HOT SPOTS TO WATCH

Source: IHSS Assessment Training CDSS 4/2005

AA Domestic Services

- *Everyone is assessed 6.00 hours per month regardless of FI score.*
- *Size of residence or lifestyle choice is not taken into consideration.*
- *Service is authorized when client resides with Able/Available spouse or is a minor child with parent provider. The total need is divided by the number living in the household without taking into consideration shared living situations.*
- *Social workers are sometimes not familiar with how to document "refused services".*

BB & CC Meal Preparation and Clean-Up

- *Needs are assessed for meals that consumers are able to prepare/clean-up without any assistance.*
- *Consumers are assessed the same amount of time regardless of what type of meals they eat (frozen dinner vs. full meal).*
- *Everyone gets the same amount of time for meal prep/clean-up regardless of what they eat or their FI score.*

DD Laundry

- *Consumers are assessed services that they are able to independently perform.*
- *Consumers are assessed extra hours for out of home laundry facilities when laundry facilities exist on the premises.*

EE & FF Shopping /Errands

- *A need is assessed for services the consumer is able to perform independently, such as go to a nearby store for small items.*
- *Consumers are assessed extra time to go to distant stores when there is a nearby store that is consistent with their needs.*
- *Extra time is allowed for consumer to accompany provider shopping.*

GG Heavy Cleaning

- *Services are allowed on a continuous basis.*
- *Alternative resources or agencies who might be willing to clean the home for free have not been considered.*
  - ☐ *Religious groups*
  - ☐ *Neighbors*
- *Justification for allowing the service is not documented in the case file.*

HH Respiration

- *Alternative resources that consumer receives are often not identified.*
- *Consumer is capable of performing the services for which a need is assessed.*

II Bowel and Bladder

- *Service is assessed when consumer experiences some difficulty performing task, however it does not put them at risk for injury, hazard or accident.*
- *A need is assessed for consumers who wear diapers but are able to manage without assistance from another person.*

JJ Feeding

- *Often services are assessed for reminding the consumer to eat, which in many cases can be done while provider is accomplishing other tasks.*

KK Bed Baths

- *A need is assessed for bed baths when the consumer is able to safely bathe in the bathroom - Only consumers who exclusively use bed baths should be authorized this service. Sponge baths are including in bathing/grooming.*

LL Dressing

- *Consumer changes clothes only once a day, however assessed need reflects numerous clothing changes.*
- *Consumer has minor need; however assessed need reflects full clothing changes.*
- *Consumer needs only occasional assistance, however need reflects daily assistance.*

MM Menstrual Care

- *A need is assessed when the consumer is able to perform the task without assistance.*
- *Need is typically monthly, however assessed need does not reflect it as such - menstrual cycles are normally only once a month, however time is sometimes assessed as a weekly need.*

NN Ambulation

- *A need is assessed for assistance moving around outside of the home – time should be related to daily activities which the consumer needs to walk (or use a wheelchair/walker) to perform, such as walking to and from the bathroom, bedroom, and kitchen. Ambulation is not authorized for general exercise purposes or for assistance walking outside of the home.*
- *Need is often based solely on the fact that the consumer uses an assistive device - just the fact that the consumer uses an assistive device; they should not automatically be assessed time for ambulation.*

OO Moving In/Out of Bed

- *Assessed need reflects more time than is actually required.*
- *Consumer is allowed time daily, however only requires assistance on bad days.*
- *Need is assessed when assistive device allows consumer to move in and out of bed without assistance.*

PP Bathing, Oral Hygiene, Grooming

- *A need is assessed for services that client is able to perform without assistance.*
- *Services are assessed daily and it is apparent that they are not being performed (consumer is not clean).*

QQ Repositioning and Transfers

- *A need is assessed when consumer can safely perform transfers without assistance from another person.*
- *Assessed need does not accurately reflect number of times assistance is required.*

RR Care and Assistance with Prosthesis

- *Assessed need reflects daily set up of medications; however provider sets up medications one time weekly.*
- *Time is assessed when consumer requires only "reminding" to take meds which requires minimal time or can be done while provider is performing other tasks.*

SS Accompaniment to Medical Appointments

- *Assessed need includes time waiting for the consumer while they are in the appointment.*
- *Assessed need does not reflect the total time needed during the month.*
    - *Convert monthly need into weekly need.*
- *Assessed need includes accompaniment to locations not consistent with regulations.*

UU Remove Grass – Weeds, Rubbish

- *Services are allowed for merely enhancing the appearance of the yard.*
- *Type of living arrangement has not been taken into consideration.*

VV Remove Ice, Snow

- *Calendar controls are not set.*
    - *Service allowed during summer months.*

WW Protective Supervision

- *Hours are not calculated correctly.*
- *Justification is not always documented in case file how the consumer places themselves in danger for injury, hazard or accident.*
- *Protective Supervision is assessed when the primary purpose is one of the following:*
    - *Friendly visiting.*
    - *The need is caused by a medical condition and the form of supervision required is medical.*
    - *In anticipation of a medical emergency or to prevent or control anti-social or aggressive consumer behavior.*

XX Teaching & Demonstration

- *Services authorized longer than 3 months.*
- *Results of service not sent to CDSS.*

YY Paramedical

- *Paramedical services are authorized before SOC 321 has been obtained.*
  - *Services should not be authorized until SOC 321 is correctly completed and in the case file.*
- *Services approved are not always paramedical in nature.*
- *The time period for which the services are authorized has expired.*
  - *Services should be reassessed every year.*

Assessment Hints

Assessment Hints: Things to Consider

Presuming consumer's Functional Level indicates a need for assistance; the following are useful in assessing the amount of service that should be authorized.

General concepts:

- ***A Social Worker gleans much information about functioning by observing the consumer as well as the condition of the home and whether a consumer lives alone or with family.***

- ***Learning and understanding how a particular diagnosis affects functioning helps the SW understand the variations in functioning among consumers with the same diagnosis.***

- ***On personal tasks (except bathing), there should be a general evaluation about how the consumer will cope if there is no provider available to serve 7 days a week.***

AA Domestic: (State Maximum Guideline)

- What is the living arrangement? How many people live in the home? Does the consumer have a separate bedroom and bathroom? Screen for proration.
- What is the consumer's mental status? Is he/she alert? Can they make rational decisions?
- Avoid judging the suitability of living situation versus the safety of the situation. The SW may not believe this is the best condition, but the check is if it is SAFE?
- What physical limitations exist?
- Look at the number and size of rooms to be cleaned. If the consumer lives in a 1 bedroom or studio apartment, consider the percentage of allowed time for the average size home and authorize appropriately.
- If the consumer suffers from incontinence necessitating frequent changes of bed linen, extra changing of the sheets should be assessed as domestic services but the washing of them is assessed as laundry.
- If the consumer has incontinence, does he have protective pads for the bed to protect linens and reduce the need for extra linen changes?

BB Meal Preparation & CC Meal Clean up

- Are there health or safety issues that prevent the consumer from preparing their own meals?
- What is the living arrangement? Screen for proration. In shared living situations, are the meals prepared together with other family members?

- What are the consumer's specific medical dietary requirements? Are they requirements that preclude the housemates from sharing meals? For example, a diabetic diet or heart diet is a healthy diet that can be shared by housemates.
- What types of meals does the consumer typically eat?
- Can the consumer chew –do they need pureed foods?
- Does the consumer need help cutting up food?
- What alternative resources could be obtained to help with meal preparation? Do they get Meals on Wheels or go to a day care center that provides meals?
- Does the consumer use the kitchen? Could they use the kitchen?
- How often is meal preparation needed? How often does the consumer eat?
- What is their Functional Index rank for Meal Preparation?
- Observe if the consumer's movements are impaired. Do they have poor strength and endurance? Can they lift pots/pans? Can they bend or stoop? Can they reach stored food or utensils?
- Ask if they can stand long enough to prepare a meal, help with clean up, wash the dishes or load the dishwasher.
- Is the consumer safe around a stove? Do they use oxygen?
- Does the consumer have a microwave? Can s/he use it?

<u>DD Laundry (State Maximum Guideline)</u>

- Provider should accomplish other tasks while clothes are washing and drying if done in the home.
- If the consumer has washer and the capability to dry clothes on the premises, laundry facilities are considered to be in the home.
- If the consumer is able to do some laundry, their assessed need would be less than the 1 hr guideline.
- Per CDSS policy "on the premises" means available within an apartment complex or mobile home park.
- If the consumer has incontinence which creates extra laundry, justification for the extra hours is required in the case file. (not everyone who is incontinent requires extra laundry)
- Does the consumer have the capability to hand wash some items?
- Is there extra laundry due to incontinence? If the consumer uses disposable diapers or disposable pads to cover the bedding and clothing, extra laundry should not be needed. If the consumer suffers from incontinence necessitating frequent changes of bed linen, extra changing of the sheets should be assessed as domestic services but the washing of them is assessed as laundry.
- Is the consumer's laundry washed separately? What is the living arrangement? Screen for proration.

<u>EE Shopping for Food (State Maximum Guideline)</u>

- What is the living arrangement? Is shopping for groceries for the entire household? Screen for proration. Is there a reason the shopping must be done separately?
- Observe the consumer's ability to move around the home. Observe the consumer's ability to reach, grasp, lift.
- Are they capable of shopping or compiling a shopping list?

- Would they get lost going to the store? In the store? Going home?
- If the consumer "prefers" items from a particular distant store but there are comparable items at a nearby store, extra time is not allowed for the provider to shop at the preferred store.
- Although the consumer may want to accompany the provider shopping, (and that is allowed) extra time should not be approved.

FF Other Shopping and Errands (State Maximum Guideline)

- For picking up prescriptions, going to the bank, shopping for clothing, getting a haircut, etc.
- What alternative resources could be obtained to help with shopping and errands?
- Although the consumer may want to accompany the provider shopping, (and that is allowed) extra time should not be approved.

GG Heaving Cleaning

- Heavy Cleaning cannot be authorized unless conditions are extreme and something significant has happened, for example, when the consumer is under threat of eviction due to the state of their apartment or fumigation has been ordered. There must be a plan in place for the consumer so that the same condition does not occur again.
- Heavy Cleaning can also be authorized once in the first month of IHSS service in order to allow regular Domestic Services to take place.
- May be authorized when: IHSS initially granted, Lapse in eligibility occurs, Eligibility is re-established, IHSS has not been provided within the previous 12 months.
- Can a provider reasonably provide routine maintenance in the home after heavy cleaning?
- Health factors should be considered when authorizing this service. Is there human or animal waste, garbage lying around, clutter that prevents the consumer from moving around the house safely?
- Are the extreme conditions the result of lifestyle choice or consumer's disability? Referral for alternative services might be needed. If this is a lifestyle choice, this service would not benefit the consumer because it would not make a difference in his future living conditions.

HH Respiration

- Observe the home for breathing equipment. Does the consumer cough or wheeze excessively during the interview? Is their breathing labored?
- What type of apparatus does the consumer use? Is the consumer physically and mentally able to hold a nebulizer or inhaler without assistance for the required time?
- Ask if they have been instructed on how to use their equipment and if they are able to manage cleaning it. How often is it done and how long does it take?
- If the consumer has an oxygen machine but can hook it up and clean it themselves, they should be considered independent with respiration.
- Is there a service that does maintenance? If the consumer has a service that assists them with the cleaning of their equipment, those needs should be shown and assessed as being met through an alternative resource.

- Does the consumer need to move the tank around? Does the consumer have a portable tank? Can the consumer move it independently? What time factors are involved and how much time per day?
- Does the consumer need help putting the apparatus on? How often is this needed and how long does it take?

II Bowel and Bladder Care

- Does the consumer have difficulty getting to bathroom in time?
- Can you smell urine/ feces in the home?
- What does the bathroom look like? Observe for signs that the consumer is not making it to bathroom in time or missing the toilet.
- What impact does the consumer's medical condition have on this function?
- What assistive devices does the consumer have? What devices would help minimize the need for assistance?
- Does the consumer use a urinal or bedside commode?
- Can the consumer complete cleaning and maintenance of the commode? If the consumer uses a bedside commode or urinal but can empty or clean it by themselves, they should be assessed as Rank 1 (independent.)
- Can the consumer stay on the commode /toilet once assisted to get on?
- Can the consumer get to commode / toilet?
- Is the consumer able to change diapers /pads?
- Is the consumer able to wipe himself?
- How many times a day does the consumer use toilet / commode if they need assist, and how long for each assist? (separate answers for bowel movement and for urination)
- Is the consumer incontinent? How often? Bowel? Bladder?
- What impact does bowel and bladder issues have on needs for laundry frequency (authorized in laundry)?
- If the consumer has ostomy bag, and the provider is only emptying the bag, services are assessed as bowel/bladder.

JJ Feeding /Hydration Assistance

- Does the consumer have medical / physical conditions that prevent him/her from grasping / holding utensils, cups, etc.? Is it difficult or impossible? Look for paralysis, tremors, weakness, arthritis, pain, or physical deformity.
- A consumer's hands may be deformed and they may have restricted ability to grasp but if they are able to feed themselves, they would still be considered independent.
- Does the consumer have a special device or brace on his hand for feeding?
- Is the consumer's condition consistent throughout the day? Does it improve after medication? Is their independence better for some meals?
- Is the consumer able to keep concentration to feed himself? Look for psychological conditions that may interfere with focus during eating e.g., psychotic disorder, severe depression, mental confusion, developmental delays or dementia. If such disorders exist, does the consumer eat if reminded? Does the provider need to sit with the consumer, encouraging him/her throughout the meal? Does the provider need to feed the consumer?

- How many times a day does the consumer eat and for each assist?
- How willing is the consumer to eat? Will they eat once you've set food in front of them, or do they need constant attention?
- When the consumer greets you, how do they shake hands with you? Do they appear extremely frail? Shaky?
- Does the consumer appear undernourished? Observe if their clothes appear too large, possibly indicating a recent weight loss. Ask them what they have eaten that day.
- If the consumer is able to feed themselves and does not need the provider's constant presence, the provider can often remind them to eat while they are doing something else….dusting, vacuuming, etc.

KK Routine Bed Baths

- Consumers who get bed baths may be bed-bound, or unable to use a shower or tub on occasion, or at all. This is not the same as a sponge bath (PP Bathing).
- Is the shower or tub too narrow for the consumer to access?
- Are there steps leading to the bathroom that the consumer cannot navigate?
- Is the consumer recovering from an injury or surgery? If so, their needs will probably be different than the long-term bed bound consumer.
- Does the consumer need to be bathed daily to prevent skin breakdown and pressure sores?
- Is the consumer incontinent? How many times a day? Some cleaning will need to occur after each episode of incontinence. Can the consumer manage that cleaning?
- How many times a week does a consumer need to be bathed to maintain safety?
- Can the consumer assist with the process at all? If so, this should be encouraged to maximize independence and promote self esteem.
- What does it take to move consumer who cannot assist?
- How long does it take to bathe the consumer?

LL Dressing

- Includes putting on and taking off a garment. Consider fastening and un-fastening garments and undergarments.
- Observe if the consumer is appropriately dressed for their environment.
- Consider life style choices~ Do they prefer to spend the day in pajamas or sweats?
- Is the consumer bed bound?
- Does the consumer use specialized garments, braces, splints etc?
- Do they frequently soil their clothing causing frequent changes?
- Does the consumer have uncontrollable tremors in extremities or missing/ deformed hands making fastening or lacing garments difficult?
- Does the consumer have devices that assist with dressing? Could they use devices that would assist them in dressing? These will lesson the need for assistance.
- How often does the consumer go out? Would the dressing need be different?
- Maximize their independence, what can the consumer do for himself?
- Do they look and appear comfortably dressed?
- Do they apologize or appear embarrassed about their state of dress?
- Are all buttons buttoned correctly? Zippers zipped? Shoes tied or fastened?

- If the consumer only changes clothing in the morning and evening or only requires occasional assistance, the assessed time should reflect that.
- If the consumer only requires assistance on "bad days" such as after dialysis treatments, the need should be assessed as such.

MM Menstrual Care
- Limited to external application of sanitary napkin and cleaning.
- Does the consumer menstruate? Regardless of the consumer's age, it is vital to ask questions as spotting might indicate a possible serious medical condition. Is her period regular? What is the duration?
- Ask what kinds of personal assistance she requires.
- Pads only, no service is available for inserting of tampons.
- Are there any mental/physical issues? Why does the consumer require assistance?
- Hours authorized should be the frequency of periods multiplied by the time each occasion multiplied by the number of days per month divided by 4.33.

NN Ambulation
- How much difficulty does the consumer have in moving around the house? Ask the consumer to show you around the house and observe their mobility.
- Does the consumer need help maneuvering the wheelchair from one room to another?
- Ask if they feel safe walking around their home.
- Can the person move around more safely using a walker /cane? Do they know how to use them properly? Do they remember to use the assistive device or leave it next to the chair when they get up and walk?
- Will the consumer use assistive devices?
- If they use a wheelchair, walker or cane but can do so safely without assistance, they should be considered independent.
- Is the consumer at risk if they are unassisted? Consider the amount of assistance needed to keep the consumer safe – stand-by versus hands-on.
- How often does the consumer move around the home? How long does it take them to get from place to place?
- Are there stairs the consumer must maneuver?

OO Moving In and Out of Bed
- Includes moving from one sitting or lying position to another sitting or lying position, such as from bed to wheelchair, or from chair to chair.
- Assess the consumer's strength, balance, flexibility, and stability on their feet.
- Does the consumer use any assistive devices? Should assistive devices be considered to improve their independence?
- Does the consumer need the assistance of a Hoyer or other type of Lift to transfer them from the bed to the wheelchair?
- Does the provider need to do a pivot transfer? Does the consumer have an appropriate belt to assist in this process?
- Can the consumer use furniture safely to get himself in and out of a position?

- Does the consumer get dizzy upon standing up? If so, ask the consumer if his/her doctor knows that this happens and if (s)he has ever fainted or fallen when that happens and recommend that the consumer goes to the doctor.
- How many times does the consumer change positions daily and how long does it take for each?
- Do they nap during the day? Do they need help every time they get in and out of bed?
- Does the consumer have trouble getting out of a chair? If so, getting out of bed would probably be even more difficult.
- Ask them if they need help getting out of bed in the morning or back in at night.

PP Bathing and Grooming

- Consider a medial condition that would increase the need from frequent bathing; diabetes (sweating), incontinence, skin allergies, or lesions which need to be kept clean. Note that the care of open lesions would be a Paramedical Service.
- What is the consumer's activity level? The more active they are, the more frequent the need for bathing.
- How often is the consumer currently being bathed? Does the consumer look clean?
- Does the consumer resist bathing (frequent with people with Alzheimer's Disease)?
- How much assistance does the consumer need? What can they do to maximize their independence?
- Does the consumer need assistance to get in/out of tub for safety, but able to bathe himself once in the tub or on a shower stool?
- Assess the need for grab bar or shower chair to promote independence.
- Frequent bathing of the elderly can cause dry skin leading to itchiness, lesions, or skin breakdown.
- Time for application of lotion/powder to the skin after bathing can be included here.
- Does the consumer need shaving? How often and how long does it take? Can the consumer shave himself with an electric shaver?
- How often does the consumer need hair washing?
- Can the consumer brush their own teeth? Floss?
- Can the consumer do their own denture care?
- Can the consumer do their own hair –comb/brush? Check out range of motion of their arms.
- Grooming does not include cutting with scissors or clipping toenails if the consumer is diabetic or has thickening of toenails.
- If toenail care is medically contraindicated, it is evaluated as a paramedical service.

QQ Repositioning, Transfer, Skin Care and Range of Motion Exercises

- Is the consumer's movement unimpaired?
- Are they able to get out of a chair unassisted?
- Are they able to reposition themselves as necessary in a wheelchair?
- Are they able to get into and out of vehicles to go to medical appointments?
- How often does the consumer move around? If bed bound, medical repositioning is standard is every 2-3 hours.
- Does the consumer need skin rubbing when repositioned to promote circulation?

- Range of motion exercises must have been taught by a licensed health care professional.
- If pressure sores have developed, the need for care of them is evaluated as a paramedical service
- Range of Motion must be approved by a licensed health care professional. It must be needed to restore mobility restricted because of injury, disuse, or disease, not for comfort or esthetic reasons.

RR Assistance with Prosthesis (Assistance w/Meds)

- How long does it take to set up a mediset? How many times a week? Consider packaging of pills from the pharmacy.
- Does the consumer's cognitive impairment make it unsafe to do self-meds setup? Is the consumer mentally competent to manage their own meds?
- If assistance with medication is more complicated, for example administering injections, the time should be counted as a paramedical service.
- If the consumer requires prosthetic devices, ask what types of assistance they require. May be assessed as "dressing" versus "care & assistance with prosthesis". But this does include charging batteries in motorized wheelchairs, if the consumer cannot perform this activity.
- When a provider must physically put the medication into a consumer's mouth or orifice this should be assessed as a paramedical service rather than assistance with prosthesis.

SS and TT Accompaniment to Medical Appointments and Alternative resources

- Accompaniment is only authorized when the consumer needs the help of a provider because of mobility problems or because the consumer gets disoriented. It is not just to fill the consumer's need for transportation.
- Does not include time waiting for an appointment to finish.
- Assistance by the provider is available for transportation when the consumer's presence is required at the destination and such assistance is necessary to accomplish the travel.
- If consumer takes a bus to appointments, time should be authorized only if the consumer cannot ambulate **outside** of the home without assistance.
- If the consumer uses taxi scripts or is driven to appointments, time should be authorized only if the consumer cannot ambulate **inside** the home without assistance.
- Consumers using medi-vans should not be authorized accompaniment time unless they are confused or disoriented.
- Accompaniment to alternative resources should only be authorized if the alternative resource does not provide its own transportation (Most adult day health centers provide their own transportation).

UU Remove Grass, Weeds, Rubbish

- Need for the service must constitute a fire or safety hazard.
- Has the consumer received a citation from the fire department or other agency?
- How long will it reasonably take to eliminate the yard hazard? Consider: size of yard, amount of weed growth, time of year.

VV Remove Ice, Snow

- How appropriate is the service?
- Must constitute a safety hazard.
- Must be from entrances and essential walkways.

WW Protective Supervision

- Protective supervision consists of observing the consumer's behavior in order to safeguard them against injury, hazard or accident.
- This service is available for monitoring the behavior of oneself-directing, confused, mentally impaired or mentally ill persons.
- Not in anticipation of a medical emergency (seizure, heart attack, there might be a fire and the consumer couldn't get out of the house if this were to happen) or to control antisocial or aggressive behavior (consumer might break neighbor's windows, has a tendency of smearing feces, may take drugs).
- A 24 hour need must exist which cannot be met through IHSS, alternative resources or a reassurance phone call.
- Ask for a description of incident(s) and date(s)? Do they wander? Do they attempt to turn on the stove or operate appliances?
- What does the consumer do when confronted with danger, crisis or hazard?
- Do they know how to act in a way that is appropriate to the situation?
- Never having an "accident" is not cause to deny services.
- Even if the consumer says that they know what to do, can they act on it?
- Is the consumer physically capable of placing themselves at risk for injury, hazard or accident? Are they bed or wheelchair bound?
- What is their mental functioning? How alert are they? Consider progression of dementia may lesson need. Needs must be reassessed yearly. Should they be assessed more often?

XX Teaching & Demonstration

- Limited to instruction in domestic tasks, related services, non-medical personal care services and yard hazard abatement.
- Provider must possess skills to effectively and safely train the consumer.
- There must be a reasonable expectation that the consumer will no longer require IHSS assistance with the task after the training, or assistance will be at a reduced level.

YY Paramedical Services

- Does the consumer require injections? Are they able to safely self administer them?
- Do they require a bowel program or other invasive medical type procedure?
- Is the consumer physically or mentally able to perform the function?
- Life support is usually not Paramedical because it doesn't meet the definition of "…are activities which persons would normally perform for themselves but for their functional limitations" Consider a referral for IHO service and perhaps the doctor should be referring for Home Health Agency care and/or hospice.
- Paramedical services cannot be authorized without a medical order (SOC321) from the consumer's physician confirming the provider has been trained in the required procedures.

Documentation

THE RIGHT AND THE WRONG WAY TO

DOCUMENT

When thinking about, "How do I document this case," always paint a solid picture of need so that a stranger without social work experience can see the Consumer's need, and will be able to justify the services authorized to meet that need. This solid picture should always identify the Consumer's functional impairments and the risk they pose to the Consumer, and should spell out how In-Home Supportive Services will reduce the risk. In addition, remove all judgmental comments; instead, simply report observed behaviors and environmental conditions.

Here are a few examples:

Wrong way: "The Consumer needs Meal-preparation services."
Right way: "Consumer has congestive heart failure, which causes her to become short-of-breath, with minor exertion. As a result, she is only able to prepare a light breakfast (she states she has more energy in the morning), and needs meal-preparation services for lunch and dinner."

[NOTES: Here the "right way" presents a description of functioning, and its connection to the specific types of services needed to address the impairment.]

Wrong way: "Consumer's house is filthy."
Right way: "During the home visit, I observed animal feces on the floor in several places. Consumer's couch appeared stained, and had the odor of urine emanating from it. I noticed a pile of unwashed dishes in the kitchen sink, and a layer of black mold in the bathroom sink."

[NOTES: Here the "right way" presents facts and detailed observations, while the "wrong way" could be an expression of the writer's judgmentalism.]

Wrong way: "Consumer needs one hour per week for Ambulation."
Right way: "During the home visit, I observed Consumer attempting to ambulate. His gait appeared unsteady--he nearly fell twice during the visit--and he stated that he is afraid to walk to the bathroom, unattended. Consumer stated that he spends approximately 8-9 minutes per day, getting to the bathroom and kitchen. This is equivalent to 1 hour per week for Ambulation."

[NOTES: MPP 30-757.14(k) defines Ambulation as, "consisting of assisting the Consumer with walking or moving the Consumer from place to place." The Annotated Assessment Criteria support this in the sections on Bathing & Grooming, and Bowel & Bladder: "Getting to and from the bathroom is evaluated as Mobility Inside." While this Consumer did not state the need for Bowel & Bladder care, once in the bathroom, if it is needed, "assisting person to and from … toilet or commode" would be considered part of Bowel & Bladder care.]

THE RIGHT AND THE WRONG WAY TO

DOCUMENT

Wrong way: "Consumer no longer needs Bathing services."
Right way: "Telephone call from Consumer. She stated that her broken wrist is completely healed, and that her Orthopedic Surgeon removed her arm-cast today. She further stated that she is now bathing for herself, unassisted. Bathing services removed as of this date."

[NOTES: In this case, the Consumer stated no further need for Bathing services, but the removal of a cast does not, per se, mean that the Consumer can return to the former functioning level immediately. It is possible that the Orthopedic Surgeon will prescribe a regimen of physical therapy to regain functioning in the Consumer's hand. If the fracture was in the Consumer's dominant hand, then it is possible that some services, such as Bathing or Dressing would need to continue until full functioning is regained.]

Wrong way: "Consumer needs total care."
Right way: "Consumer has Multiple Sclerosis, and she spends the entire day in bed. She lacks the physical strength and endurance to reposition, transfer, toilet, ambulate, bathe, dress, feed herself, clean her house, shop or run errands, prepare meals or clean-up afterward, or do her laundry."

[NOTES: Here the "right way" presents a description of functioning, and its connection to the specific types of services needed to address the impairment.]

Wrong way: "Consumer needs Protective Supervision."
Right way: "According to the physician's evaluation, the Consumer has a diagnosis of dementia from Alzheimer's disease and a history of wandering in the street, unable to recognize danger."

[NOTES: Here the physician's evaluation suggests elements of the Consumer's behavior and cognitive limitations that could assist the SW in concluding that Protective Supervision is warranted. However, a full evaluation by the SW, using the Protective Supervision criteria found in MPP 30-757.17 et seq., and the Annotated Assessment Criteria needs to be completed.]

Wrong way: "Consumer was uncooperative."
Right way: "Three months ago, I suggested to Consumer that the local Senior Center would be a resource for him, for both socialization and daily lunches. To date, he continues to state a feeling of isolation and difficulty affording meals; however he has not contacted the Senior Center yet."

[NOTES: Services for all adult Consumers are voluntary. Thus, Consumers have the right to refuse services, and not to follow the SW's suggestions. While, from the SW's perspective, going to the Senior Center could reduce both social isolation and the cost of daily lunches, there may be many reasons why the consumer has chosen not to follow this suggestion. Thus, the "right way" describes the Consumer's statements and actions, while the "wrong way" suggests uncooperativeness.]

HEY, HEY, HEY, READ ALL ABOUT IT!

IHSS Social Workers are Documenting! Documenting! Documenting!

Documentation is important in each and every one of our IHSS cases; it allows the reader to have a visual picture of what took place while the social worker was in the home, and what has transpired since the home visit. This is important when, and if, the case is transferred to another worker or another county. It lays a foundation, which a consumer's history is built on. Case narrative is the readers visual picture of what has been going on with the consumer, his/her family dynamics, living environment, provider history and any changes in the consumer's health conditions.

Documentation / Narrative will be a valuable resource to you when you need to fall back on certain dates and times that a particular incident took place. It can be anything from a consumer being hospitalized, to a consumer alleging abuse by a caretaker. (Remember however, narrative alone is not enough if there is an allegation of abuse, you must also cross-report any abuse to APS/Law Enforcement on a SOC 341).

When documenting your case it is simple, just pretend that you work for the local news paper, no it is not the Daily Planet, it is the "IHSS" or the "Independent Helping Services Sentinel". Sentinel means "Look out, or Guard" which is the job of each social worker to look out for the best interest of their consumer, and guard them against possible fraud, or neglect. As a reporter for the Sentinel, it is your job to be accurate, grab the reader's attention and tell a story that will allow your reader to be there with you.

Remember you are a star reporter, the Clark Kent of Social Services, you may not have a cape, and phone booths are really hard to find these days, but you have something more powerful, and that is you are a social worker. You are providing services to the elderly and dependent adult allowing them to remain in their own home as long as possible. So what you need to do to insure safety, and insure that your consumer is receiving the appropriate services, is simple, just follow the rules of journalism: Who, What, When, Where, How, and Why. So grab your mighty pen, which can write faster than a speeding bullet, o.k. maybe not faster, but pretty quickly, and practice the following:

Who is calling you?	The client, doctor, family member, Lois Lane, or a friend?
What are they calling you about?	Need a new provider, changes in their medical conditions, no longer in the home, hospitalized, can't find a phone booth or just needing information about other community resources that may be available to them.
When did the incident occur?	Was it today, yesterday, last week, last year or will it be sometime in the future.
Where was the client when it occurred?	In her own home, in the hospital or racing a locomotive.

How has this affected the client?	Emotionally, physically, financially? Did the provider quit, or has consumer hired a new provider.
Why did this happen?	Was it because of the consumer, the provider, a family member? Was it because of bills were not being paid, or because of theft?

*Remember the importance of documentation: "If it isn't documented it did not happen."

State Hearings:
When going to a State Hearing, it is important that you have completed an assessment tool, covering each area of service, and documented the home visit. The State Hearing Judge will rely on documented information from your case, and testimony from you, the consumer, and other witnesses. If you did not document certain events, and the consumer denies that you addressed these issues, it will be a case of "he said, she said" and the Judge usually will err on the side of the consumer. So for better results on those rare occasions when you have a case that is appealed by a consumer, you need to make sure that your documentation is accurate, filed appropriately in your case, and that it allows the reader reviewing your case to build a visual picture of what transpired during your home visit, and how you came up with your assessments, and the hours you granted or denied.

If you follow the simple rules of journalism, who knows-one day when a new social worker comes down the road and picks up one of your cases they may say "Wow who was that Super Social Worker?!!!!!!!"

Self-Care/Time Management

Social Worker Self-Care & Refueling

Sustaining Your Creative Edge

Self Care Exercise Instructions:
Step 1 - Individually take a few moments to answer the following questions, take your time, these questions are thought provoking.
Step 2 – When you've completed answering the questions find a partner and discuss how each of you answered the questions.
Step 3 - Come back together as a group to discuss this exercise and its impact on you.

1) Describe in detail what attracted you to your current job/profession as a social worker?

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2) List 3 things that are fulfilling about your job now.

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2._____
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3._____
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3) List ways your profession adds value to humanity.

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4) What is most important to you in doing your job well?

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Ten Quick Time Management Tips

From Melissa C. Stöppler, M.D.
Your Guide to Stress Management

Find more minutes in your day.

If you need more than 24 hours in a day but don't have the energy for a major scheduling overhaul, here are ten quick time management tips you can start using now to help you squeeze a few more precious minutes out of your day.

1. **Don't waste waiting time.** Waiting for other people shouldn't be an active, time-consuming part of your day. For the inevitable times when you must wait, find ways to put even a few minutes' waiting time to good use. Whether on hold on the telephone or waiting for a meeting or appointment, you can make lists, sort mail, go over your schedule, or complete small but necessary tasks. At home, sort the laundry or the mail while catching up on the news, talk on the phone while preparing dinner, etc.

2. **Stock up on the small items** you frequently run out of or make special trips to purchase.

3. If space permits, **buy nonperishable groceries and household goods in quantities** to last at least for 2-3 months. Your supermarket visits will be reduced to quick trips to pick up fresh items.

4. If you're working at home or even trying to finish a necessary housekeeping task, **turn off the telephone** until the job is done. Leaving the answering machine on may be too great a temptation to interrupt your work and chat. If you absolutely have to screen calls, put the machine on low volume in another room while you work.

5. **Make medical and dental checkup appointments well in advance** (months if necessary), and ask for the earliest morning appointment. If the practice takes a midday break, you can also ask to be placed first on the afternoon schedule. That way, you'll be seen immediately and won't waste time in the waiting room.

6. **Capitalize on your body rhythms**. You know when you're at your peak mentally and physically; schedule the most demanding tasks for these periods. You'll work more efficiently and save time.

7. **Try an Internet reminder service** to keep track of important dates or events. You can program them to receive calls, email, or pages to remind you of anything you don't want to forget or miss. Most of these services are free.

8. **Organize your clothes closet** to insure a speedy start to your day. Be brutally honest and weed out anything that you don't love, that doesn't fit, or that you don't feel good wearing. If you can't bear to part with it for sentimental reasons, pack it away if it won't be worn. No matter how much you paid for it, if you don't wear an article of clothing, it's just adding to closet clutter.

9. In the office, **cultivate a friendly but businesslike personality** while at your desk. Remain polite but unwelcoming to those who want to interrupt while you're busy. Being always available to unannounced visitors or coworkers eager for a chat can eat up a major portion of your day. Limit socializing to areas away from your workspace, so you're projecting a consistent message.

10. If you need to schedule meetings or appointments that have the potential to drag on indefinitely, try **scheduling them right before lunch or near the end of the business day**. With everyone thinking of getting away for lunch or for the evening, there's less potential for a marathon session.

http://stress.about.com/cs/timemanagement/a/aa041601.htm

The Cure: Refueling Your Tank

What percentage of the time do you get an adequate amount of each of these?

		0	10	20	30	40	50	60	70	80	90	100%
1.	Proper rest											
2.	Good nutrition											
3.	Daily exercise											
4.	Time alone											
5.	Time to read and learn											
6.	Spiritual growth											
7.	Intimacy and love											
8.	Fun, joy, and play											
9.	Quality time with family and friends											
10.	New interests or hobbies											
11.	Regular vacations											
12.	Sense of purpose											

Choose one area that is low and creatively brainstorm some ways to increase the time devoted to this area by 10% over the next month. The purpose in setting a modest goal is to be sure it is attainable. Set yourself up to win. Let both your intuition and your logic tell you which is most important to improve. Frequently, a small improvement in one critical area can make a big difference.

Adapted from: "You don't have to go home from work Exhausted!"
By: Ann McGee-Cooper, 1992

Say No to Responsibility Overload

From Melissa C. Stöppler, M.D.,

You can control some aspects of your stress burden.

Many "stressed out" people are not poor stress managers- they are simply overloaded with commitments and responsibilities. In this case, stress arises from an overbooked schedule or a greater number of responsibilities than one can reasonably handle.

Perhaps you recognize the signs of "responsibility overload" in your own schedule. Despite a major upcoming deadline and long hours, you find yourself agreeing to organize the office holiday party. Although your afternoons are already packed, you end up coaching your daughter's soccer team. You're president of your tenants' association because you did it last year and hate to let your neighbors down. Most of us know the feeling of wondering why we ever agreed to take on yet one more responsibility. Even school-age children can experience stress from an overloaded extracurricular schedule.

Finding things to eliminate (and to decline, in the future) in a too-busy schedule can help you not only to reduce stress, but also provides you with more time for yourself and more energy to deal with your remaining commitments. Look closely at how you spend your non-working, non-sleeping hours. Examine your social, family and community commitments and ask yourself: Is this a true *obligation* for me? It's up to *you* to decide which activities you feel are most important and cannot be missed. Do I *want* to do this? Will this activity or event bring me joy? Will my participation bring joy or happiness to someone important to me? Looking at your schedule with a critical eye will help you to target areas in which you can make cutbacks.

Many people report that they assume too many responsibilities because they do not want to be perceived as lazy or unhelpful, or because they do not want to be seen as letting others down. For many, learning to say no to others' requests is the most difficult time management task. Although it seems like a simple step, a large number of people admit that they often agree to requests because they have difficulty refusing them. In this case it is helpful to actually rehearse how you will react next time you are asked to take on a responsibility you don't want to accept. Practice the following responses if you need help saying "no":

"I'm not taking on any more charity/volunteer/community/ projects right now."
"Sorry, I'm just not able to plan that far ahead now."
"I've got so much on that I'm not scheduling anything new right now."
"We're having a quiet holiday with just the family this year."

"I really don't feel that I'd be able to provide the required commitment level to do justice to the project."

Remember, you do not owe others an explanation or defense of your choices. Deliver your answer with a friendly smile and refuse to be drawn into a debate or discussion. For more practical tips on saying 'no,' psychologist Dr. Linda D. Tillman writes about "The Power of Saying 'No'" and gives advice for those "people pleasers" who readily agree to any request.

As with all changes and improvements, learning to free yourself from overloaded and unwanted responsibilities is a skill you can improve with time, leading ultimately to a more balanced life and better stress management.

http://stress.about.com/cs/copingskills/a/aa100700.htm

The Power of Saying, "No" - by Linda D Tillman, PhD

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"No" is such a simple word....
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only two letters. Yet saying "No" out loud is harder for most people than saying, "I'll be glad to..." (eleven letters) or "When do you need me to..." (seventeen letters)

Most of us said, "No!" quite well when we were two. After all, it's the two-year-old's job to say "No." The authority figures in our lives at the time, our parents, expect us to say "No." And it is because of "No" that the year is known as the Terrible Two's.

Many of us grow up to be people pleasers. The word "No" drops out of our vocabulary, and we substitute lots of ways to be agreeable and keep the other person happy. Saying "No" to the authority figures is not expected. And underneath it all we believe that saying "No" can cost us a lot in our adult life.

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The unassertive "No"
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is accompanied by weak excuses and rationalizations. If you lack confidence when you say "No" you may think that you need to support your "No" with lots of reasons to convince the other person that you mean it.

You might even make up an excuse to support your "No." This can backfire if the lie is exposed and again, you will sound ineffective because you need to have an excuse to support your stand.

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The aggressive "No"
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is done with contempt. "Are you kidding? Me, get your mail while you're out of town?"

Sometimes the aggressive "No" includes an attack on the person making the request. "You must be crazy. I couldn't take on a project that unimportant."

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The assertive "No"
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is simple and direct. "No, I won't be able to help with that." If you would like to offer an explanation, make it short and simple. "No, I won't be able to help with that. I've already made a commitment for Friday afternoon."

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Strategies to make the assertive "No" easier
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1. When someone makes a request, it is always OK to *ASK FOR TIME TO THINK IT OVER*. In thinking it over, remind yourself that the decision is entirely up to you.

2. Use your nonverbal assertiveness to underline the "No." Make sure that your voice is firm and direct. Look into the person's eyes as you say, "No." Shake your head "No," as you say, "No."

3. Remember that "No," is an honorable response. If you decide that "No," is the answer that you prefer to give, then it is authentic and honest for you to say, "No."

4. If you say, "Yes," when you want to say, "No," you will feel resentful throughout whatever you agreed to do. This costs you energy and discomfort and is not necessary if you just say, "No" when you need to.

5. If you are saying, "No," to someone whom you would help under different circumstances, use an empathic response to ease the rejection. For example, to your friend who needs you to keep her child while she goes to the doctor, you might say, "No, Susie, I can't keep Billie for you. I know it must be hard for you to find someone at that time of day, but I have already made lunch plans and I won't be able to help you."

6. Start your sentence with the word, "No." It's easier to keep the commitment to say, "No," if it's the first word out of your mouth.

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Practicing for the World Series
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Let's look at some daily ways you can practice saying, "No," so that it comes more naturally to you. Paulette Dale in her book, Did You Say Something, Susan? suggests some simple ways to practice saying, "No." Here are some of her suggestions:
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Say "No,"
to the clerk who wants to write your phone number down when you return something to the store;
to the telemarketer who disturbs your dinner;
to the perfume demonstrator at the department store;
to your friend's pets when they jump on you;
to the secretary who answers the phone and asks if you mind if she puts you on hold.

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Make it a project to say, "No," to something every day.

When you do, notice it and give yourself credit for practicing saying such an important two letter word.

Linda D Tillman, PhD
www.speakupforyourself.com
Linda D Tillman, PhD is a clinical psychologist and coach, working with people to speak up for themselves in life and work. You can find her web site at www.speakupforyourself.com Her email address is: linda@speakupforyourself.com

http://stress.about.com/gi/dynamic/offsite.htm?site=http://www.selfgrowth.com/articles/tillman6.html